**LIVING ASSURANCE / EPCC CLAIM**
**DOCTOR'S STATEMENT**

Great Eastern
A member of the OCBC Group

**DOCTOR'S STATEMENT FOR:**
**MUSCULAR DYSTROPHY**

* Please delete where appropriate

For Official Use
G E L S –

Name of Life Assured:

NRIC/ Passport No.:

Date of Birth (dd/mm/yyyy):

Gender: M / F *

1. Are you the Life Assured's usual medical doctor? YES / NO*

   If "YES", since what date? Day Month Year

2. (a) Date when Life Assured first consulted you for Muscular Dystrophy: Day Month Year

   (b) Please state symptoms presented and date symptoms first appeared.

| Symptoms Presented at First Consultation | Date Symptoms First Started (D/M/Y) |
|---|---|
| | |
| | |
| | |

   What is the source of this information? Patient / Referring Doctor / Others*

   If "Others", please specify: _____

   (c) Please provide full and exact diagnosis of the Life Assured's condition.

   _____

   _____

   (d) Date when illness / condition was FIRST diagnosed: Day Month Year

   (e) Diagnosis was first made by (name of doctor): _____

   (f) Date when Life Assured first became aware of the illness / condition: Day Month Year

_____ Date

_____ Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

3. (a) Please provide details of all investigations performed (e.g. muscle biopsy, electromyogram, serum creatinine, phosphokinace etc).

(b) Please provide details, including dates, of the extent of the neurological deficit.

(c) Please give details of current treatment.

4. (a) Has the Life Assured previously suffered from the condition specified above or any possible related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? YES / NO*

If "YES", please give dates of consultations, the resulting diagnosis, the name and the address of the doctor.

(b) Are you aware of any blood relative suffering from a similar or related illness? YES / NO*

If "YES", please state the relationship, nature of illness, the date of diagnosis and the source of information.

(c) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*

If "YES", please state illness, date of first diagnosis, name and address of attending doctor.

5. (a) Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he / she consulted you? YES / NO*

If "YES", please give name(s) and address(es) of the doctor(s) whom he / she consulted.

| Name of Doctor | Name of Clinic / Hospital and Address |
|---|---|
| | |
| | |
| | |

Date

Signature of Doctor

(b) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants attended.

6. Given the Activities of Daily Living (ADL) definitions stated below, please confirm which of the following the Life Assured is able / unable to undertake:

(a) **Bathing**

Is the Life Assured able to do the following without assistance:

Wash? YES / NO*

Shower? YES / NO*

Maintain adequate personal cleanliness? YES / NO*

If "NO", please state why and how much assistance is required and how long (in weeks or months) since the Life Assured became unable to perform these tasks.

(b) **Dressing**

Is the Life Assured able to dress himself fully without assistance? YES / NO*

Can he unaided, put on and take off medically necessary appliances usually worn (e.g. braces, artificial limbs or other surgical appliances)? YES / NO*

If "NO", please state why and how much assistance is required and on what date the Life Assured became unable to perform these tasks.

(c) **Toileting**

Is the Life Assured able to go to the toilet or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene without assistance? YES / NO*

If "NO", what is the reason for the Life Assured's restriction and how much assistance is required, and on what date did the Life Assured became unable to perform these tasks?

(d) **Feeding**

Is the Life Assured able to consume (but not necessarily prepare) food and drink without assistance? YES / NO*

If "NO", please give details of the underlying problems and the amount of assistance required and on what date did the Life Assured become unable to perform these tasks.

Date

Signature of Doctor

(e) **Mobility**

Is the Life Assured able to move indoors from room to room on level surface without assistance? YES / NO*

If "NO", please state why and how much assistance is required and on what date the Life Assured became unable to perform these tasks.

(f) **Transferring**

Is the Life Assured able to move from a bed to an upright chair or wheelchair and vice versa without assistance? YES/NO*

If "NO", please state why and how much assistance is required and on what date the Life Assured became unable to perform these tasks.

7. (a) Please describe the Life Assured's mental and cognitive abiliites.

(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

8. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

9. Please provide us with any other additional information that will enable the Company to assess this claim.

Date

Signature & Official Stamp of Doctor