LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MAJOR ORGAN TRANSPLANTS / MAJOR ORGANS / BONE MARROW TRANSPLANTATIONS

* 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 any major organ failure that ultimately require organ transplantation: 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) What was the exact diagnosis of the underlying disease leading to the major organ transplantation?

_____

_____

(d) Date when illness / condition that require organ transplant was FIRST diagnosed: Day Month Year

(e) Diagnosis was first made by (name of doctor): Day Month Year

(f) Date when Life Assured first became aware of the organ failure: 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

CCLM
CCLMDOCLAP

Jun 2017

(g) Has the Life Assured previously suffered from the above or any related illness? YES / NO*
If "YES", please give dates of consultations, the resulting diagnosis, the name and address of the attending doctor.

_____

_____

3. (a) Prior to the transplantation,

(i) Was there irreversible end-stage failure of the relevant organ? YES/NO*

(ii) What medical treatment or replacement therapy had the Life Assured been receiving, e.g. Dialysis, blood transfusions?

_____

_____

(iii) When did such treatment commence?

Day		Month		Year			

(b) Date when the major organ / bone marrow was transplanted:

Day		Month		Year			

(c) Was it a bone marrow transplant or a major organ transplant: _____

If major organ transplant, state the organ transplanted and advise whether the entire organ or part of the organ transplanted.

_____

(d) Was it the first graft? YES / NO*

If "NO", please give date of the first graft:

Day		Month		Year			

(e) How long was the Life Assured on a waiting list for the operation? Since:

Day		Month		Year			

(f) Please provide the name and address of the hospital where the surgery was performed.

_____

_____

(g) Who performed the surgery? (Please state name and address)

_____

_____

_____ _____

Date Signature of Doctor

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4. For bone marrow transplant:

   Please confirm if the source of the transplanted bone marrow was obtained from another human bone marrow. YES / NO*

5. For small bowel transplant:

   Please confirm if at least one meter of small bowel is transplanted due to intestinal failure. YES / NO*

   If "YES", please provide details.

   _____

   _____

6. For cornea transplant:

   Please confirm that the whole cornea transplant is due to irreversible of scarring and resulted in reduced visual acuity that cannot be corrected with any other methods. YES / NO*

   If "YES", please provide details.

   _____

   _____

7. (a) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

   _____

   _____

   (b) Is there anything in the Life Assured's personal medical history and family history that would have increased the risk of this illness? YES / NO*

   If "YES", please give full details including the relationship, nature of illness, date of diagnosis, name and address of the doctor and source of information.

   _____

   _____

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

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

   _____

   _____

_____ _____

Date Signature of Doctor

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8. (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*

9. (a) Did the Life Assured consult any other doctors for this injury / disease / condition 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

(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.

_____

_____

10. Please state and attach copies of all relevant transplantation, hospital, operation and investigation reports.

_____

_____

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

_____

_____

_____

_____
Date

_____
Signature & Official Stamp of Doctor