JUNIOR LIVING ASSURANCE / MAXCARE JUNIOR CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BRAIN SURGERY

* Please delete where appropriate

For Official Use

G E L S –

O A C S –

Name of Life Assured:

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

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

(b) If "YES", since what date? Day Month Year

(c) Over what period do your records extend? From Day Month Year to Day Month Year

(d) If you are not the Life Assured's usual medical doctor, please provide the name, address and qualification of the Life Assured's usual medical doctor.

2. (a) Date when Life Assured consulted you for this illness: 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) Diagnosis: _____

3. (a) Please provide the full and exact details of the diagnosis.

Date

Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

(b) Date when illness was FIRST diagnosed: Day | Month | Year

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

(d) Date when the Life Assured first became aware of the condition: Day | Month | Year

(e) Date when the Life Assured's PARENT first became aware of the condition: Day | Month | Year

4. (a) Please give details (with dates) of the nature and type of surgery performed.

_____

_____

(b) Was a craniotomy performed?

_____

_____

(c) Was a surgery required to remove blood clot?

_____

_____

5. Was surgery required due to an accident? YES / NO*

(a) If "YES", state date of accident: Day | Month | Year

(b) Where and how did the accident occur?

_____

_____

6. Please provide details of all investigations performed and attach a copy of the laboratory / investigation results.

_____

_____

7. Has the Life Assured previously suffered from the condition specified above or any related illnesses? YES / NO*

If "YES", please give details including dates of consultations and the resulting diagnosis.

_____

_____

_____ _____

Date Signature of Doctor

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8. 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

9. Please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

10. Does the Life Assured have any personal history of any other major medical or psychiatric condition? YES / NO*

If "YES", please give details including nature of condition, date of onset, treatment received and current status of the condition.

11. Does the Life Assured have any family history of any major medical condition? YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

12. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor

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