JUNIOR LIVING ASSURANCE / MAXCARE JUNIOR CLAIM DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BONE MARROW TRANSPLANT

* Please delete where appropriate

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 first 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) What was the underlying condition for which the Life Assured required a bone marrow transplant?

    _____

    _____

_____
Date

_____
Signature of Doctor

CCLM

CCLMDOCJLA

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

_____

_____

(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) Has the Life Assured undergone bone marrow transplantation or been placed on the official waiting list for a transplant, as a recipient?

_____

_____

(b) In which hospital was the transplant performed?

_____

_____

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

_____

_____

(d) 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

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

Name of Doctor	Name of Clinic / Hospital and Address

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

_____

_____

6. 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.

_____

_____

7. 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.

_____

_____

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

_____

_____

_____

_____   _____
Date   Signature & Official Stamp of Doctor