LIFE WOMAN ENHANCED BENEFITS CLAIM DOCTOR'S STATEMENT



Please delete where appropriate	For Official Use
	GELS-
Name of Life Assured:	
NRIC/ Passport No.: Date of Birth (dd/m	nm/yyyy): Gender: M / F
. Date of Hospitalisation:	
(i) Date Admitted Day Month Year Date Discharge	ged Day Month Year
(ii) Date Admitted Day Month Year Date Discharge	ged Day Month Year
(iii) Date Admitted Day Month Year Date Discharge	ged Day Month Year
2. State the period in which the baby was in an incubator. From Day Month Year To Day Month Year To	
3. When were you first consulted for this illness?	
What is the diagnosis and on which date was the diagnosis made?	
i. Please provide details (include dates) of surgical or other treatment given.	
Date	Signature of Doctor



Plea	ase provide the name	and address of the doctor:				
(a)	who had referred the	e Life Assured to you.				
(b)	to whom you had ref	erred this Life Assured.				
Plea	ase attach copies of re	elevant laboratory reports to	o assist us in asses	sing the claim.		
Plea	ase provide any other	information which may be	of assistance to us	in assessing this	claim.	
	Date			-	Signature & Office	cial Stamp of Doctor