TERMINAL ILLNESS CLAIM - DOCTOR'S STATEMENT

(To be completed by the Life Assured's attending medical specialist)

Important Notes:

(1) Please attach copies of the following, where applicable:

(a) All relevant investigation reports such as histopathology or biopsy report, imaging studies, laboratory and other reports.

(b) Referral letter (if any).

(2) Please circle the questions below where appropriate.

Details of Life Assured

Full Name: _____

NRIC / Passport No.: | | | | | | | | | | | | |

Details of Medical Condition

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

Symptoms presented	Date symptoms first started (DD/MM/YY)

(2) Date when the Life Assured first consulted you for the condition? D D / M M / Y Y Y Y

(3) Date when illness / condition was FIRST diagnosed: D D / M M / Y Y Y Y

Date when Life Assured first became aware of the diagnosis: D D / M M / Y Y Y Y

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

_____

Diagnosis was first made by (name of doctor):

_____

(4) Is Life Assured's condition in any way related to:

(a) AIDS, AIDS-related complex or infection by HIV?	Yes	No
(b) Congenital anomaly or defect?	Yes	No
(c) Alcohol abuse or misuse?	Yes	No
(d) Drug abuse or use of drug not prescribed by registered medical practitioner?	Yes	No
(e) Attempted suicide or self-inflicted injuries?	Yes	No

(5) Please elaborate the treatment plan that the Life Assured is currently receiving. For medications, please state the type of medication and dosages.

_____

_____

Signature of Doctor _____ Date _____

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Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com; Website: greateasternlife.com

(6) Please state the date of Life Assured most recent consultation/examination. D D / M M / Y Y Y Y

Does the Life Assured compliance to medication and treatment? Yes No

Is his/her disability progressive, stationary or improving? Please explain in details.

(7) In your opinion, if the Life Assured terminally ill (life expectancy of 1 year or less)? Yes No

If yes, please state the date the Life Assured is assessed to be terminally ill. D D / M M / Y Y Y Y

Please explain and give supporting medical evidence to support your above opinion.

(8) Is the Life Assured mentally capacitated of receiving or handling money? Yes No

Please describe his/her mental and cognitive abilities.

(9) Did the Life Assured consult any other doctor for this illness of its symptoms BEFORE he/she consulted you? If Yes, please state details. Yes No

Date of consultation	Name and Address of Doctor

(10) Is the Life Assured suffering or has suffered from similar condition or other significant illnesses? Yes No

If Yes, please state the details.

Date of First Diagnosis	Medical Condition	Name and Address of Attending Doctor

(11) Does the Life Assured have any family history? Yes No

If Yes, please state the details.

Relationship to Life Assured	Age of onset	Nature of Condition

Signature & Official Stamp of Doctor

Date