LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BACTERIAL MENINGITIS

* 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 Bacterial Meningitis: 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) Please provide full and exact diagnosis of the Life Assured's condition.

   _____

   _____

   (d) Date when illness / condition was FIRST diagnosed:

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

   (f) Date when Life Assured first became aware of the illness / condition: 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

3. (a) Has the Life Assured previously suffered from Bacterial Meningitis or any possible related illness? YES / NO*

If "YES", please give dates of consultations, the resulting diagnosis, name and address of the doctor who made these diagnosis and source of information.

(b) Please state if there is inflammation of the membranes of the brain or spinal cord. YES / NO*

(c) Please provide details, including dates, of the extent of the neurological deficit.

(d) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's meningitis? YES / NO*

If "YES", please describe the neurological deficit.

(e) Is this neurological deficit likely to be permanent? YES / NO*

If "NO", please provide details.

(f) Please provide details of investigations performed on the cerebrospinal fluid and blood culture, stating the types of organism found in each.

(g) Please give details of current treatment.

(h) Is the Life Assured HIV positive? YES/ NO*

If "YES", please give full details.

Date

Signature of Doctor

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4. (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*

5. (a) 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

(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.

_____

_____

(c) Is the Life Assured suffering or has suffered from any other significant illness? YES / NO*
If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

_____

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6. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

_____

_____

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

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

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