LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BENIGN BRAIN TUMOUR OR SUBDURAL HAEMATOMA

* 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 Benign Brain Tumour or Subdural Haematona:: 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 Benign Brain Tumour or Subdural Haematoma was FIRST diagnosed: Day Month Year

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

(f) Date when Life Assured first became aware of the Benign Brain Tumour or Subdural Haematoma: 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

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

_____

_____

(b) Is the Life Assured's condition life threatening? YES / NO*

(c) Has it caused any damage to the brain? YES / NO*
If "YES", please give full details.

_____

_____

This section is applicable to benign brain tumour only.

4. (a) Has the tumour caused an increase in the intracranial pressure? YES / NO*
If "YES", please give full details of life threatening condition and/or neurological deficit suffered.

_____

_____

(b) Has the Life Assured undergone any surgical removal of the tumour? YES / NO*
If "YES", please state:

(i) Type of surgery: _____

(ii) Date of surgery:

Day		Month		Year			

(c) If the tumour has not been surgically removed, has it caused any neurological deficits? YES / NO*
If "YES", please state:

(i) What are the neurological deficits?

_____

_____

(ii) Are the neurological deficits permanent? YES / NO*

(d) Is the LIfe Assured's condition a cyst, a granuloma, vascular malformation in or of the arteries of the brain or haematomas? YES / NO*

If "YES", please state the type.

_____

_____ _____

Date Signature of Doctor

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(e) Is the Life Assured's tumour of the pituitary gland or spine cord? Please state.

_____

(f) Has the tumour been totally or partially surgically eradicated? YES / NO*
If "YES", please give details of histology.

_____

_____

This section is applicable to subdural haematoma condtion only.

5. (a) Was the cause of subdural haematoma a result of an accident? YES / NO*
If "YES", please state:

(i) Date of accident:

Day		Month		Year			

(ii) Is there external visible injury resulting from the accident? YES / NO*

(iii) Please state mode of investigation done to establish the subdural haematoma (e.g CT scan, MRI, etc.). Please include a copy of the investigation report.

_____

_____

(b) Was the subdural haematoma drained through a burr hole surgery? YES / NO*
If "NO", please state the treatments provided.

_____

_____

6. (a) Has the Life Assured previously suffered from Benign Brain Tumour or any related illness? YES / NO*
If "YES", please give dates of consultations, the resulting diagnosis and the name and address of the attending doctor.

_____

_____

(b) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

_____

_____

(c) Please give details of the Life Assured's habits in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

_____

_____

Date

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(d) 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 the name and address of attending doctor.

7. (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*

8. (a) Did the Life Assured consult any other doctors for this injury / disease / condition 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.

9. Please state and attach copies of all relevant hospital reports, laboratory and tests results e.g Magnetic Resonance Imaging (MRI), computerised tomography or other reliable imaging techniques.

10. 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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