LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
DIABETIC COMPLICATIONS

For Official Use
G E L S –

Please attach copies of the following (if applicable):

1. Laser Photocoagulation report
2. Fluorescent Fundus Angiography report
3. Visual acuity results
4. eGFR result
5. All relevant hospital / operation reports, laboratory and test results

* Please delete where appropriate

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 Diabetes: Day Month Year

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

Symptoms	Duration of Symptoms	Date Symptoms First Started (DD/MM/YYYY)

What is the source of the above information? Patient / Referring Doctor / Others*

If "Referring Doctor / Others", please specify name & address:

Name	Address

(c) Date when diabetes was FIRST diagnosed: 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

Jun 2017

CCLM
CCLMDOCLAP

(d) Diagnosis was first made by (name of Doctor): _____

(e) Date when Life Assured first became aware of this illness: Day | Month | Year

(g) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

_____

_____

3. Was Life Assured diagnosed with diabetic retinopathy? YES / NO*

If "YES", please state the date of diagnosis: Day | Month | Year

4. (a) Date of most recent visual acuity test: Day | Month | Year

(b) Please provide result of the most recent visual acuity test.

_____

_____

5. Did Life Assured undergo Fluorescent Fundus Angiography test? YES / NO*

(a) If "YES", please provide the date: Day | Month | Year

(b) Please provide result of the Fluorescent Fundus Angiography test.

_____

_____

6. Did Life Assured undergo Laser Photocoagulation? YES / NO*

(a) If "YES", please provide the date of this procedure: Day | Month | Year

(b) Please provide result of Laser Photocoagulation.

_____

_____

_____ _____

Date Signature of Doctor

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7. Was Life Assured diagnosed with diabetic nephropathy? YES / NO*

If "YES", please state the date of diagnosis:

Day		Month		Year			

8. Is the eGFR of the Life Assured <30ml/min/1.73m2? YES / NO*

Please provide result of the eGFR.

_____

_____

9. Was Life Assured diagnosed with gangrene resulting from diabetes complication? YES / NO*

If "YES", please state precise area of gangrene.

_____

_____

10. Was amputation of at least an entire foot performed to treat gangrene? YES / NO*

If "YES", please state the date of surgery:

Day		Month		Year			

Please state exact location of amputation.

_____

_____

11. (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*

12. Does the Life Assured have any other medical conditions? YES / NO*

If "YES", please state medical condition, date of diagnosis and name & address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

_____ _____

Date Signature of Doctor

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13. Does the Life Assured have any family history? YES / NO*

If “YES”, please provide details including relationship to the Life Assured, the medical condition and age of onset.

Relationship to the Life Assured	Medical Condition	Age of Onset

14. 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.

15. Please give details of the Life Assured’s habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

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

Date

Signature & Official Stamp of Doctor

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