LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
CHRONIC LIVER DISEASE / END STAGE LIVER FAILURE

* 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 any illness that led to End Stage Liver Failure/Liver Cirrhosis/Liver problem: 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) Did the Life Assured at any time prior to final diagnosis consult you for liver disease? YES / NO*
If "YES", please give full details.

_____

_____

(d) Date the Life Assured became aware of a general deterioration in condition: Day Month Year

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

_____
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

3. (a) Is there end-stage liver failure? YES / NO*

If "YES", please provide the date when end stage liver failure was FIRST diagnosed:

Day		Month		Year			

(b) Please provide full detailed results and dates of serial liver function tests done (to include Gamma GT and Bilirubin levels).

(c) How long has the Life Assured been jaundiced? Please confirm if it would be permanent.

(d) Were there signs of hepatic encephalopathy? YES / NO*
If "YES", please give full details.

(e) Was there ascites? YES / NO*
If "YES", please provide date detected and mode of detection (clinical, paracentesis etc).

(f) Please provide full and exact details of the diagnosis, including any test or investigations performed.

(g) Is the liver disease secondary to alcohol or drug abuse? YES / NO*
If "YES", please give full details.

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(h) Is there partial hepatectomy of at least on entire lobe of the liver? YES / NO*

If "YES", please provide the following information:

(i) Date of surgery:

Day		Month		Year			

(ii) Reason(s) for requiring hepatectomy.

(iii) Was partial hepatectomy absolutely necessary? Please explain.

(i) Is there cirrhosis of the liver? YES / NO*

If "YES", please provide the HAI-Knodell Scores with liver biopsy report.

4. (a) Is there anything in the Life Assured's habits or personal medical history which would have increased the risk of Chronic Liver Disease? YES / NO*

If "YES", please give full details including the date of diagnosis and source of information.

(b) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*

If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

5. (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*

Date

Signature of Doctor

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6. (a) Did the Life Assured consult any other doctor for 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, together with the names of the consultants attended.

7. Please state and attach copies of all relevant hospital reports, laboratory and test results.

8. 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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