LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
HIV DUE TO ORGAN TRANSPLANT

Please attach copies of the following (if applicable):

1. Antibody tests
2. All relevant hospital / operation reports, laboratory and test results

* 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 AIDS / HIV due to Organ Transplant: Day Month Year

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

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

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

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

Name	Address

(d) Please provide exact diagnosis.

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

(e) Date when illness was FIRST diagnosed: Day | Month | Year

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

(g) How was the diagnosis made?

_____

_____

(h) Please provide the dates of HIV or antibody test performed and the results of these tests.

Date of Tests (DD/MM/YYYY)	Types of Tests	Results of Tests

(i) Date when Life Assured first became aware of the diagnosis: Day | Month | Year

3. Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*

If "YES", please give details.

_____

_____

4. Was HIV due to Organ Transplant? YES / NO*

(a) If "YES", please state date of Organ Transplant: Day | Month | Year

(b) Type of Organ Transplant

_____

_____

(c) Reason for Organ Transplant

_____

_____

_____ _____

Date Signature of Doctor

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(d) Was the Organ Transplant given as part of a medical treatment? YES / NO*

If "YES", please provide:

(i) Date of first consultation: Day | Month | Year

(ii) Date of first diagnosis: Day | Month | Year

(iii) Diagnosis date: Day | Month | Year

(iv) Name and address of the hospital where the transplant took place.

_____

_____

5. Was the patient suffering from Thalassaemia Major or Haempohillia? YES / NO*

6. Was the hospital able to track the origin of the HIV tainted blood? YES / NO*

If "YES", please provide full details.

_____

_____

7. Has a cure for HIV / AIDS become available prior to the time the Life Assured was being infected? YES / NO*

If "YES", please provide details.

_____

_____

8. Is the Life Assured at greater risk of HIV infection due to any aspect of his / her lifestyle, e.g drug use, sexual orientation? YES / NO*

If "YES", please provide details.

_____

_____

9. (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*

_____ _____

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

If"YES", please state the 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

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

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

Relationship to the Life Assured	Nature of Condition	Age of Onset

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

13. 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.

14. 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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