LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MOTOR NEURONE DISEASE

* 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 Motor Neurone Disease : 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 (including type of motor neurone disease e.g. amyotrophic lateral sclerosis etc).

   _____

   _____

   (d) Date when illness/condition 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 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

Jun 2017

CCLM
CCLMDOCLAP

3. (a) Please provide details of any investigations performed (e.g. electromyogram, nerve conduction studies, MRI etc).

_____

_____

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

_____

_____

(c) Are these likely to be permanent? YES/NO*

(d) Please give details of current treatment.

_____

_____

4. (a) Has the Life Assured previously suffered from the condition specified above or any possible related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? YES/NO*
If "YES", please give dates of consultations, the resulting diagnosis, the name and the address of the doctor.

_____

_____

(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*

6. (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

_____

Date

_____

Signature of Doctor

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(b) Please provide the names and address of any hospital or clinic to which the Life Assured was referred and 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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