LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
SURGERY TO THE AORTA

* 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 or condition which led to Surgery to the Aorta: 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 details of the diagnosis or condition which required corrective Surgery to Aorta.

_____

_____

(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 become aware of condition requiring cardiac or abdominal Surgery to Aorta: 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) What was the type of surgery performed?

_____

_____

(b) Surgery was performed to repair or correct:

(i) Aneurysm YES / NO*

(ii) Narrowing YES / NO*

(iii) Dissection of the Aorta YES / NO*

(c) Was surgery performed by surgical opening of the chest or abdomen? YES / NO*

(d) Was surgery performed on the the thoracic or abdominal aorta and not its branches? YES / NO*

(e) Was surgery performed using any minimally invasive or intra-arterial technique? YES / NO*

(f) Name and address of doctor who performed the surgery.

_____

_____

(g) Hospital where the surgery was performed.

_____

(h) Date of surgery:

Day		Month		Year			

(i) If surgery was not performed, please state degree of aortic aneurysm or dissection. Please attach a copy of tests results.

_____

(j) Where did the aneurysm or dissection occur?

_____

_____ _____

Date Signature of Doctor

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This section is applicable to abdominal or thoracic aortic aneurysm or dissection (not its branches) conditions only.

4. (a) Please tick the condition which the Life Assured suffered from:

- Abdominal Aortic Aneurysm ☐
- Abdominal Aortic Dissection ☐
- Thoracic Aortic Aneurysm ☐
- Thoracic Aortic Dissection ☐

(b) Date of FIRST diagnosis of abdominal or thoracic aneurysm or dissection:

Day		Month		Year			

(c) Details leading to the diagnosis of the abdominal or thoracic aortic aneurysm or dissection.

_____

_____

(d) Diameter of the abdominal or thoracic aortic aneurysm or dissection (in millimeter). Please include a copy of the investigation report.

_____

_____

5. (a) Have you previously treated the Life Assured for any risk factors or related illnesses, e.g hypertension, angina, other vascular disease or endocarditis? YES / NO*

If "YES", please provide the following:

Medical Condition	Date of 1st diagnosis	Name of Doctor	Name and Address of the clinic/ hospital

_____ _____

Date Signature of Doctor

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(b) Is there anything in the Life Assured's personal medical history and family history which would have increased the risk of abdominal or thoracic aortic aneurysm or dissection? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

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

(d) Is the Life Assured suffering from any other significant illnesses? YES / NO*
If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

6. (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*

7. (a) Did the Life Assured consult any other doctor for this illness of 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 address of any hospital or clinic to which the Life Assured was referred and the names of the consultants attended.

Date

Signature of Doctor

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8. Please state and attach copies of all relevant hospital report, laboratory and test results related to this illness.

9. 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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