LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

DOCTOR'S STATEMENT FOR:
PULMONARY ARTERIAL HYPERTENSION / PULMONARY HYPERTENSION

* Please delete where appropriate

For Official Use

G E L S –

O A C 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 pulmonary hypertension: 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.

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   (d) Is the pulmonary hypertension due to primary or secondary causes? Please explain.

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______________________________ Date

______________________________ Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLMDOCLAP

Jan 2015

(e) Date when illness was FIRST diagnosed:

Day		Month		Year			

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

(g) Date when Life Assured first became aware of the illness:

Day		Month		Year			

3. (a) Is the disease associated with any underlying causes or conditions, or related to any congenital condition? YES / NO*
If "YES", please provide full details.

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(b) Is there presence of right ventricular hypertrophy? YES / NO*
Please attach a copy of echocardiogram report.

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(c) Was cardiac catherterization carried out to establish the pulmonary hypertension? YES / NO*
Please attach a copy of the cardiac catherterization report.

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(d) Please give results of any investigations performed, e.g, chest X-rays, ECG's echocardiograph, cardiac catherterization and any other tests. Please attach copies of the reports or test results.

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(e) (i) Does Life Assured have any cardiac/physical impairment which fulfills the New York Heart Association of Cardiac Impairment criteria? YES / NO*

(ii) If "YES", please state the class of impairment. Class I / II / III / IV*

(iii) Please provide details of current symptoms.

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______________________ ______________________
Date Signature of Doctor

(f) (i) What treatment has been administered?

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(ii) What treatment is currently being administered?

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(g) Has transplantation been considered? YES / NO*
If "YES", please provide full details.

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4. (a) 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.

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(b) Did the Life Assured consult any other doctor 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

(c) Please provide the name(s) and address(es) of any hospital or clinic to which the Life Assured was referred to, together with the names of the attending doctor(s).

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____

Date

Signature of Doctor

5. (a) Please describe the Life Assured's mental and cognitive abiliites.

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(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

6. Please state and attach copies of all hospital reports, cardiac catherterisation reports, other laboratory and test results.

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7. Please provide us with any other additional information that will enable the Company to assess this claim.

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Date

Signature & Official Stamp of Doctor

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