LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
CANCER / MAJOR CANCERS

Please attach copies of the following (if applicable):

1. All histopathology / biopsy reports
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 Cancer: 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) Date when Cancer was FIRST diagnosed: 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

(f) Actual Diagnosis: _____

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

Day		Month		Year			

(h) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

_____

_____

3. (a) What is the staging of the tumour?

_____

_____

(b) Please state the tumour classification (e.g. TMN classification etc).

_____

_____

(c) Please confirm the following:-

(i) Was the cancer completely localised? YES / NO*
(ii) Was there invasion of tissues? YES / NO*
(iii) Were regional lymph nodes involved? YES / NO*
(iv) Were there distant metastases? YES / NO*

4. (a) Did the Life Assured undergo any surgery YES / NO*

If "YES", state date of surgery:

Day		Month		Year			

If "YES", please indicate the surgical procedure performed.

_____

_____

(b) Was there any other mode of treatment, other than surgery, which could be undertaken to treat the Life Assured's condition? YES / NO*

If "YES", please specify type of treatment?

_____

_____

_____ _____

Date Signature of Doctor

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(c) Has the Life Assured underwent other mode of treatment? YES / NO*

If "YES", please state the date of treatment.

Day		Month		Year			

If "NO", why not?

5. What other forms of treatment did the Life Assured undergo (e.g. chemotherapy, radiotherapy etc.)?

6. If diagnosis is leukaemia, please provide the type of leukaemia.

7. If the diagnosis is malignant melanoma, please give full details of size, thickness (Breslow classification) and/or depth of invasion (Clark level).

8. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? YES / NO*

If "YES", please provide the date of diagnosis for HIV / AIDS?

Day		Month		Year			

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*

Date

Signature of Doctor

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

If “YES”, please state 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 habits 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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