LIVING ASSURANCE / EPCC CLAIM **DOCTOR'S STATEMENT**



DOCTOR'S STATEMENT FOR: CANCER / MAJOR CANCERS	Γ	For Official Use
Please attach copies of the following (if applica	able):	G E L S -
1. All histopathology / biopsy reports	L	
 All relevant hospital / operation reports, labo Please delete where appropriate 	ratory and test results	
Trease delete where appropriate		
Name of Life Assured:		
NRIC/ Passport No.:	Date of Birth (dd/mi	m/yyyy): Gender: M / F
NIC/ Fassport No	Date of Bitti (dd/fili	Gender. M / F
1. Are you the Life Assured's usual med	dical doctor?	YES / NO*
Day N	Month Year	
If "YES", since what date?		
	Day Month	Year
2. (a) Date when Life Assured first co	nsulted you for Cancer:	
(b) Please state symptoms present	ed and date symptoms first appeared.	
Cumptomo	Duration of Symptoms	Date Symptoms First Started
Symptoms	Duration of Symptoms	(DD/MM/YYYY)
(c) What is the source of the above	e information?	Patient / Referring Doctor / Others*
. ,		. and it , its string 2000, , earlies
If "Referring Doctor / Others", pl	lease specify name & address:	
Name		Address
(d) Date when Cancer was FIRST	Day Month Year diagnosed:	
(e) Diagnosis was first made by (na	ame of Doctor):	
Date		Signature of Doctor



(f)	1	Actual Diagnosis:	
(g) [Date when Life Assured first became aware of this illness:	
(h		Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? If "YES", please give details.	YES / NO*
3. (a	-) \ -	What is the staging of the tumour?	
(b	-) F -	Please state the tumour classification (e.g. TMN classification etc).	
(c)	(Please confirm the following:- (i) Was the cancer completely localised? (ii) Was there invasion of tissues? (iii) Were regional lymph nodes involved? (iv) Were there distant metastases?	YES / NO* YES / NO* YES / NO* YES / NO*
4. (a	ı	Did the Life Assured undergo any surgery If "YES", state date of surgery: If "YES", please indicate the surgical procedure performed.	YES / NO*
(b		Was there any other mode of treatment, other than surgery, which could be undertaken to treat the Li If "YES", please specify type of treatment?	ife Assured's condition? YES / NO*
	-		Signature of Doctor

	(c)	Has the Life Assured underwent other mode of treatment?	YES / NO
		If "YES", please state the date of treatment. If "NO", why not?	
_	100		
5.		at other forms of treatment did the Life Assured undergo (e.g. chemotherapy, radiotherapy etc.)?	
6.	If dia	iagnosis is leukaemia, please provide the type of leukaemia.	
7.	If the	ne diagnosis is malignant melanoma, please give full details of size, thickness (Breslow classification) and/or depth of el).	invasion (Clar
3.	Is th	he diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	YES / NO
).	If "Y (a)	YES", please provide the date of diagnosis for HIV / AIDS?	
	(b)	Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)?	YES/NO*
		Date Signature of Doctor	or

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 O Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number cigarettes smoked per day and source of information.	Medical Co		9	me & address of treating doctor.	
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	cigarettes smoked pe	r day and source o	of information.		
		the Life Assured's	habit in relation to alcoho	l consumption including the amount of alcoho	l consumption per da
	3. Please give details of				
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		ation.			
4. Please provide any other information which may be of assistance to us in assessing this claim.	and source of informa				
	and source of informa		ich may be of assistance	to us in assessing this claim.	
	and source of informa		ich may be of assistance	to us in assessing this claim.	
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Signature & Official Stamp of Doctor

Date