

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



## **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 |
|-----|-------|------|
|     |       |      |
|     |       |      |
|     |       |      |

| Day | Month | Year |
|-----|-------|------|
|     |       |      |

2. (a) Date when Life Assured first consulted you for Cancer:

(b) Please state symptoms presented and date symptoms first appeared.

| Symptoms | Duration of Symptoms | Date Symptoms First Started<br>(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](mailto:wecare_sg@greateasternlife.com), Website: [greateasternlife.com](http://greateasternlife.com)



CCLM

CCI MDCCI AP

(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?  
\_\_\_\_\_  
\_\_\_\_\_

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Date

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Signature of Doctor

(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?

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

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

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

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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 abilities.

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

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Date

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Signature of Doctor

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<br>(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 |
|----------------------------------|---------------------|--------------|
|                                  |                     |              |
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|                                  |                     |              |

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.

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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.

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14. Please provide any other information which may be of assistance to us in assessing this claim.

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Date

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Signature & Official Stamp of Doctor