LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
PARKINSON'S DISEASE

* 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 Parkinson's disease:: Day Month Year

(b) Please state symptoms presented and date of symptoms of Parkinson's disease when 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 diagnosis of the Life Assured's condition.

(d) Date when illness / condition was FIRST diagnosed: Day Month Year

(e) Please confirm if the Parkinson's Disease is idiopathic in nature? YES / NO*
(All other forms of Parkinsonism are excluded)

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: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMDOCLAP

08/2024

(f) Please provide details of any investigations performed to confirm the diagnosis of Parkinson's disease.

_____

_____

(g) Diagnosis was first made by (name of doctor): _____

(h) Date when the Life Assured first became aware of Parkinson's disease:

Day		Month		Year			

3. (a) Please provide details, including dates and the extent of neurological deficit suffered.

_____

_____

(b) Please give details of current treatment received for Parkinson's disease.

_____

_____

(c) Did Parkinson's disease result from treatment for any other illness, or is it associated with any other disease, e.g Wilson's disease or Huntington's Chorea? YES / NO*

If "YES", please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.

_____

_____

(d) Can the condition be controlled with medication? YES / NO*

Please state date when medical treatment first started.

Day		Month		Year			

(e) Are there signs of progressive impairment? YES / NO*

(f) Is the Life Assured able to perform the following daily activities without assistance?

(i) Washing - The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(ii) Dressing - The ability to put on, take off, secure and fasten all garments and when appropriate, any braces, artificial limbs or other surgical appliances. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

_____ _____

Date Signature of Doctor

(iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(iv) Mobility - The ability to move indoors from room to room on level surfaces. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygience. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(vi) Feeding - The ability to feed oneself once food has been prepared and made available. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

4. (a) Has the Life Assured previously suffered from Parkinson's disease or any other related illness? YES / NO*

If "YES", please state dates of consultations, resulting diagnosis, name and address of the doctor who made these diagnosis and source of information.

_____

_____

(b) Is the Life Assured suffering or has suffered from any other significant illness? YES / NO*

If "YES", please state illness, date of first diagnosis and the name and address of attending doctor.

_____

_____

5. (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

6. (a) Did the Life Assured consult any other doctors for this injury / disease / condition 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

(b) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants attended.

_____

_____

7. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

_____

_____

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

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor