ACCIDENT CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

For Official Use
G E L S –

Name of Life Assured:

NRIC/ Passport No.:

1. Date of Accident: Day Month Year

Date of first consultation for this current condition: Day Month Year

Date(s) of subsequent consultation(s):

If the Life Assured had consulted another doctor before consulting you, please give name and address of that doctor.

2. (a) Detailed description of the injuries.

(b) Please state the diagnosis:

(c) Detailed description of the accident.

(d) Were the injuries the result of the accident described above? YES / NO*

(e) (i) Were there any underlying illnesses/ conditions that attributed to the accident? YES / NO*

If "YES", please provide full details of condition (including the type of condition, the date of onset, the extent of physical/ mental infirmity) and describe how it attributed to the accident.

(ii) What was the proximate cause of the injuries/ disabilities?

Date

Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Health Claim Services 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

(f) Was the Life Assured under the influence of alcohol/ drugs at the time of the accident? YES / NO*

If "YES", please state blood alcohol content/ drug type and quantity consumed: _____

(g) Did the injuries result from a self-inflicted act? YES / NO*

If "YES", please give full description.

_____

_____

3. (a) What is the Life Assured's occupation and nature of work?

_____

_____

(b) Please state the period of Total Disability

(i) Period of *Total Disability: From: Day Month Year To: Day Month Year

*Total Disability refers to disability which prevents the Life Assured from performing each and every duty of his occupation.

(ii) Were medical certificates issued for the above stated period? YES / NO*

If "NO", please provide reasons: _____

_____

(iii) How and to what extent does the Life Assured's total disability prevent him/ her from performing all duties of his/ her occupation as stated above?

_____

_____

(iv) If the Life Assured is still totally disabled, how long is the total disability expected to last?

_____

(c) Please state the period of Partial Disability

(i) Period of **Partial Disability: From: Day Month Year To: Day Month Year

**Partially Disability refers to disability which prevent the Life Assured from performing one or more duty of his occupation.

_____ _____

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(ii) Were medical certificates issued for the above stated period? YES / NO*

If "NO", please provide reasons: _____

_____

(iii) What are some of the duties and to what extent of the Life Assured's occupation that he/ she is unable to perform as a result of his/ her partial disabilities?

_____

_____

(iv) If the Life Assured is still partially disabled, how long is the partial disability expected to last?

_____

(d) If Life Assured had been hospitalised or had undergone surgery, please state:

(i) Date admitted: Day Month Year (ii) Date discharged: Day Month Year

(iii) Name of Hospital: _____

(iv) Nature of Surgical Procedure: _____

_____

(v) Date of Surgical Procedure: Day Month Year

(vi) Is further surgery likely to be required? YES / NO*

If "YES", please specify tentative date of surgery: Day Month Year

4. (a) Was the Life Assured suffering from any illness/ infirmity which was likely to protract the period of disability? YES / NO*

If "YES", please give details:

(i) Date of first diagnosis: Day Month Year (ii) Diagnosis: _____

(iii) Name and address of doctor who made diagnosis:

_____

(iv) How it protracts the period of disability:

_____

_____

(b) What would be the usual recovery time if the Life Assured did not have the illness/ infirmity?

_____

_____

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5. Did the Life Assured suffer any fractures, dislocations or burns? YES / NO*

If "YES", please tick where applicable.

(i) Fractures of hip or pelvis (excluding thigh or coccyx)

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Mulitple fractures, at least one complete ☐ Others fractures

(ii) Fractures of thigh or heel

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ Other fractures

(iii) Fractures of lower leg, skull, claride, ankle, elbows, upper or lower arm (including wrists but excluding collen-type fractures)

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Depressed fracture of the skull needing surgical intervention ☐ Other fractures

☐ Multiple fractures, at least one complete

(iv) Fractures of collen-type fracture of the lower arm

☐ Compound fracture ☐ Other fractures

(v) Fractures of shoulder blade, knee cap, sternum, hand (excluding fingers and wrists), foot (excluding toes or heel)

☐ All compound fractures ☐ Other fractures

(vi) Fractures of spinal column (vertebrae but excluding coccyx)

☐ All compressions fractures ☐ All spinous, transvere process of pedicle fractures

☐ Fracture leading to permanent neurological damage ☐ Other vertebrae fractures

(vii) Fractures of lower jaw

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ Other fractures

(viii) Fractures of rib or ribs, cheek bone, coccyx, upper jaw, nose, toe or toes, finger or fingers

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ Other fractures

Date

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(ix) Burns: 2nd or 3rd degree burns on

☐ at least 27% of body surface ☐ at least 18% of body surface

☐ at least 9% of body surface ☐ at least 4.5% of body surface

(x) Dislocations requiring surgery under anaesthesia

☐ Spine or back, diagnosed by X-ray (excluding slipped disc) ☐ Hip

☐ Knee ☐ Wrist or elbow

☐ Ankle, shoulder blade or collarbone ☐ Fingers, toes or jaw

☐ Internal injuries resulting in open abdominal or thoracic surgery (excluding hernia)

6. Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO*
If "YES", please state.

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

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

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

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