Attending Physician's Statement – Death Claim

To be completed by the Attending Physician at the claimant's expense

C 0 5 0 6 0 8 1

Policy No. | | | | | | | | | | |

Patient's Name _____ Sex ☐ Male ☐ Female Age :_____

NRIC No. _____ Height: _____ Weight: _____ Date measured:_____ (DD/MM/YYYY)

1. Deceased's Address at Time of Death	1. _____
2. Occupation at Time of Death	2. _____
3. Last Date of Working / For how long was the Deceased confined to home and/or prevented from attending to his/her occupation.	3. _____
4. a) Are you the regular doctor of the Deceased? b) For how long have you known the Deceased?	4. (a) ☐ Yes ☐ No (b) _____
5. Please state name, address & contact no. of the doctor who referred the Deceased to you.	5. _____ _____
6. Did you attend to the Deceased during his last Illness? If "Yes", for what illness? What was the condition?	6. ☐ Yes ☐ No _____ _____
7. Date of Your First and Last Visit. What was the complaint?	7. First Visit _____ (DD/MM/YYYY) Last Visit _____ (DD/MM/YYYY) _____ _____
8. Date and Time of Death	8. _____ _____ _____ ☐ A.M. ☐ P.M. (DD/MM/YYYY) HR MIN
9. (a) Cause of Death (b) Underlying Disease & for how long? (c) Complications & for how long? (d) Other significant disease the Deceased had suffered and for how long?	9. (a) _____ (b) _____ (c) _____ (d) _____
10. Was an inquest or post-mortem examination held on the body? If "Yes", please furnish certified copy of verdict or findings.	10. ☐ Yes ☐ No
Complete 11 - 13 only if the cause of death is due to an accident	
11. Date and Time of Accident	11. _____ _____ _____ ☐ A.M. ☐ P.M. (DD/MM/YYYY) HR MIN
12. Place of Accident	12. _____
13. Details of Accident	13. _____ _____ _____

14. (a) When & where did the Deceased first seek medical treatment for his/her last illness or disease first diagnosed? (b) What was the diagnosis & was the Deceased informed of the disease/condition?	14. (a) _____ (DD/MM/YY) _____ (b) _____ _____
15. How long did the Deceased suffer from the last illness before seeking medical treatment?	15. _____ _____

16. Please give a summary of medical treatment given.

Treatment Dates (DD/MM/YYYY)	Symptoms Complained	Treatments / Management	Name and Addresses of Clinics / Hospitals

17. Names and addresses of other physicians who attended to the Deceased for his last illness and prior illness.

Names of Physicians / Hospitals	Addresses	Date of Attendances	Illnesses or Conditions Treated

18. Was the Deceased a smoker? If "Yes", please state daily smoking amount and no. of years smoked.	18. ☐ Yes ☐ No _____
19. Did the smoking habit contribute to the death of the Deceased?	19. ☐ Yes ☐ No
20. Did the Deceased consume any alcohol or use any drugs? If "Yes", please state daily consumption, amount and type of drugs used, and also the no. of years of this habit to the death of the Deceased.	20. ☐ Yes ☐ No _____ _____
21. Did the use of drugs or alcohol contribute to the death of the Deceased?	21. ☐ Yes ☐ No
22. Please state any other special causes, directly or indirectly in the habits or occupation of the Deceased, for his death	22. _____ _____
23. Any further information which, in your opinion, will assist us in assessing the claim?	23. _____ _____ _____

I hereby certify that I have personally examined and treated the Assured for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp) (DD/MM/YYYY)

_____

Contact No. _____