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Attending Physician's Statement – Death Claim To be completed by the Attending Physician at the claimant's expense

	* C Ø 5 Ø 6 Ø 8 1 *		Policy No.					
Patient's Name Sex Male Female Age :								
			Height:					
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?	4.	(a) Yes No					
	b) For how long have you known the Deceased?		(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.						
9.	(a) Cause of Death	9.	(a)					
	(b) Underlying Disease & for how long?		(b)					
	(c) Complications & for how long?		(c)					
	(d) Other significant disease the Deceased had suffered and for how long?		(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					
Со	Complete 11 - 13 only if the cause of death is due to an accident							
11.	Date and Time of Accident	11.						
			(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?		14. (a)	i. (a)(DD/MM/YY)						
	What was the diagnosis & was the Deceased informed of the lisease/condition?	(b)							
15. How illnes	long did the Deceased suffer from the last ss before seeking medical treatment?	15							
Trea	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									
If "Ye	the Deceased a smoker? es", please state daily smoking amount no. of years smoked.	18. Yes	No						
	he smoking habit contribute to the death e Deceased?	19. Yes	No						
any of the same of	he Deceased consume any alcohol or use drugs? es", please state daily consumption, unt and type of drugs used, and also the of years of this habit to the death of the eased.	20. Yes	□ No						
	he use of drugs or alcohol contribute to leath of the Deceased?	21. Yes	No						
or in	se state any other special causes, directly directly in the habits or occupation of the cased, for his death	22.							
	further information which, in your opinion, issist 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.									
Signature	e of Attending Physician			Qualification					
Name & (Official S	AddressStamp)			Date(I	DD/MM/YYYY)				
Contact N	No								