AIA PUBLIC TAKAFUL

## Attending Physician's Statement – Death Claim

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

* K 0 6 0 8 1 3 6 *

Certificate No. | | | | | | | | | | |

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

IC No. _____ Height: _____ Weight: _____ Date measured:_____ (MM/DD/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?<br>b) For how long have you known the Deceased? | 4. (a) ☐ Yes ☐ No<br>(b) _____ |
| 5. Please state name, address & contact no. of the doctor who referred the Deceased to you. | 5. _____<br>_____ |
| 6. Did you attend to the Deceased during his last Illness? If "Yes", for what illness? What was the condition? | 6. ☐ Yes ☐ No<br>_____<br>_____ |
| 7. Date of Your First and Last Visit.<br>What was the complaint? | 7. First Visit _____ (MM/DD/YYYY) Last Visit _____ (MM/DD/YYYY)<br>_____<br>_____ |
| 8. Date and Time of Death | 8. _____ (MM/DD/YYYY) _____ Hour _____ Minute ☐ A.M. ☐ P.M. |
| 9. (a) Cause of Death<br>(b) Underlying Disease & for how long?<br>(c) Complications & for how long?<br>(d) Other significant disease the Deceased had suffered and for how long? | 9. (a) _____<br>(b) _____<br>(c) _____<br>(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. _____ (MM/DD/YYYY) _____ Hour _____ Minute ☐ A.M. ☐ P.M. |
| 12. Place of Accident | 12. _____ |
| 13. Details of Accident | 13. _____<br>_____<br>_____ |

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

16. Please give a summary of medical treatment given.

| Treatment Dates (MM/DD/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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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|---|---|
| 18. Was the Deceased a smoker?<br><br>If "Yes", please state daily smoking amount and no. of years smoked. | 18. ☐ Yes ☐ No<br>_____ |
| 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?<br><br>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<br>_____<br>_____ |
| 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. _____<br>_____ |
| 23. Any further information which, in your opinion, will assist us in assessing the claim? | 23. _____<br>_____<br>_____ |

I hereby certify that I have personally examined and treated the Person Covered 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) (MM/DD/YYYY)

_____

Contact No. _____