



Attending Physician's Statement – Death Claim

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



Policy No.

Policy number input box

Patient's Name _____ Sex Male Female Age : _____

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

Main body of the form with 10 numbered questions regarding the deceased's address, occupation, medical history, and death details.

Complete 11 - 13 only if the cause of death is due to an accident

Additional form section for accidents with questions 11, 12, and 13 regarding date, place, and details of the accident.

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

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

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

<u>Names of Physicians / Hospitals</u>	<u>Addresses</u>	<u>Date of Attendances</u>	<u>Illnesses or Conditions Treated</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Qualification _____

Name & Address _____
(Official Stamp)

Date _____
(DD/MM/YYYY)

Contact No. _____