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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				
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)	(DD/MM/YY)						
(b	b) What was the diagnosis & was the Deceased informed of the disease/condition?	(b)							
15. H ill	ow long did the Deceased suffer from the last ness before seeking medical treatment?	15							
<u>T</u>	Please give a summary of medical treatment given. Treatment Dates Symptoms Complained Treatments / Management Name and Addresses of Clinics / Hospitals (DD/MM/YYYY)								
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	/as the Deceased a smoker? "Yes", please state daily smoking amount and no. of years smoked.	18. Yes	s No						
	id the smoking habit contribute to the death fthe Deceased?	19. Yes	s No						
ai If ai ne	id the Deceased consume any alcohol or use ny drugs? "Yes", please state daily consumption, mount and type of drugs used, and also the b. of years of this habit to the death of the eceased.	20. Yes	s No						
	id the use of drugs or alcohol contribute to be death of the Deceased?	21. Yes	s No						
OI	lease state any other special causes, directly r indirectly in the habits or occupation of the eceased, for his death	22							
	ny further information which, in your opinion, ill 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.									
Signat	ture of Attending Physician			Qualification					
	& Addressal Stamp)			Date	(DD/MM/YYYY)				
Conta	ct No.								