

DEATH CLAIM - DOCTOR'S STATEMENT

Important Note :

Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.
(For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

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1. Deceased's Details

Full Name

NRIC / OLD IC / Passport No

Occupation & exact duties

2. Medical Record

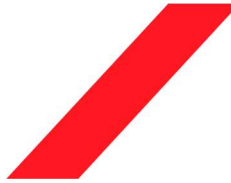
Date of Death <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Height : _____ cm Weight : _____ kg
Are you the Deceased's regular doctor? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, since when? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
First SYMPTOM ONSET Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Date when the illness was FIRST diagnosed <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
Cause of death _____ _____	Underlying Cause of Death _____ _____

Has the Deceased previously suffered from or been detected to have hypertension, diabetes, angina, hyperlipidemia, cardiovascular disease, transient ischemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disease, pre-malignant condition, cancer or any other significant illnesses?

YES NO

If YES, please provide the following :

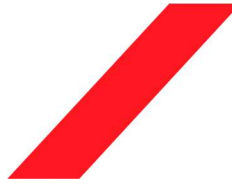
Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name of Clinic / Hospital and Address



Was the Deceased hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please state the Name of Hospital : _____ _____												
Date of FIRST admission <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY	Date of Last admission <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>											
DD	MM	YY											
<input type="text"/>	<input type="text"/>	<input type="text"/>											
DD	MM	YY											
Name(s) of attending doctor(s) in the Hospital. _____ _____													
Was other doctor referring the Deceased to you? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please state the name(s) and address(es) of the attending doctor(s) _____ _____												
Name of doctor(s) and hospital(s) that made the diagnosis _____ _____	Was the Deceased / family been informed of the diagnosis? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not available												
Was the Deceased hospitalized in the past three years? <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>If YES, please provide the details :</p> <table border="1"> <thead> <tr> <th>Date of Admission (dd/mm/yyyy)</th> <th>Name of Hospital</th> <th>Name of Attending Doctor</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Date of Admission (dd/mm/yyyy)	Name of Hospital	Name of Attending Doctor									
Date of Admission (dd/mm/yyyy)	Name of Hospital	Name of Attending Doctor											

3. Cause of Death – Other than Illness

Please attach ALL relevant laboratory evidences / test available such as : <input type="checkbox"/> Post Mortem Report <input type="checkbox"/> Alcohol / Drug Test Result	
Is the cause of death related to any of the following? If yes, please tick (v)	
<input type="checkbox"/> AIDS / HIV Positive <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Fall from Height / Building <input type="checkbox"/> Industrial / Accident at Work <input type="checkbox"/> Violation of Laws / Strike / Riots	<input type="checkbox"/> Professional Sports / Sporting activities <input type="checkbox"/> Suicide <input type="checkbox"/> Drowning <input type="checkbox"/> Fire / Explosion <input type="checkbox"/> Others : _____
Others, Please specify : _____	
In your opinion / investigation, do you think that the death was resulted from accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	If NO, what do you think was the cause of death? Please elaborate in detail. _____ _____



4. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Signature and Official Stamp

Name :

Address :

Date :