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 DD MM YY	Height : _____ cm Weight : _____ kg
Are you the Deceased's regular doctor? ☐ YES ☐ NO	If YES, since when? DD MM YY
First SYMPTOM ONSET Date DD MM YY	Date when the illness was FIRST diagnosed 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? ☐ YES ☐ NO	If YES, please state the Name of Hospital : _____ _____
Date of FIRST admission ☐☐ ☐☐ ☐☐ DD MM YY	Date of Last admission ☐☐ ☐☐ ☐☐ DD MM YY
Name(s) of attending doctor(s) in the Hospital.	_____ _____
Was other doctor referring the Deceased to you? ☐ YES ☐ 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? ☐ YES ☐ NO ☐ Not available

Was the Deceased hospitalized in the past three years?
☐ YES ☐ NO

If YES, please provide the details :

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 :
☐ Post Mortem Report ☐ Alcohol / Drug Test Result

Is the cause of death related to any of the following? If yes, please tick (√)

☐ AIDS / HIV Positive
☐ Road Traffic Accident
☐ Fall from Height / Building
☐ Industrial / Accident at Work
☐ Violation of Laws / Strike / Riots
☐ Professional Sports / Sporting activities
☐ Suicide
☐ Drowning
☐ Fire / Explosion
☐ Others :

Others, Please specify : _____

In your opinion / investigation, do you think that the death was resulted from accident? ☐ YES ☐ 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.

	Name :	
	Address :	
Signature and Official Stamp	Date :	