Death Claim Form
Physician's Statement

PART 2 – PHYSICIAN'S STATEMENT (to be completed by the attending Physician at claimant's expense)

A) Deceased's Particulars

Name of Deceased	Gender

NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Deceased's Medical Records

1) Are you the deceased's usual medical physician? **Yes** ◯ **No** ◯

If "Yes", please state date (ddmmyyyy) and

Department of FIRST consultation at your hospital.

If "No", please provide name and address of the deceased's regular doctor.

2) Please state symptom(s), date(ddmmyyyy) FIRST presented and the diagnosis:

Details of Symptoms 1st presented	Date Symptom 1st started	Exact Diagnosis

3) Please state the details include name and address of doctor FIRST consulted for the symptom(s):

Name & Address of Doctor	Date 1st consulted	Type of Treatment

4) Name and address of any doctor who had attended to the deceased during the last 3 years

Brief Description of Illness(es)	Date(s) Diagnosed	Diagnosis	Name & address of Doctor(s)

C) Details of Death

1) What was the primary cause of death?

2) How long has the illness/condition been existed prior to death?

3) What was the exact information/diagnosis conveyed to the deceased?

4) What other signaificant condition did the deceased suffered from?

Brief Description of Illness(es)	Date(s) Diagnosed	Name & Address of Doctor(s)

5) Was there any predisposing cause of the deceased's death? **Yes** ◯ **No** ◯
(e.g. use of alcohol, narcotics, etc. Family history, occupation or previous sickness)
If "Yes", please provide full details including the date of commencement (ddmmyyyy) and source of information.

6) Was the death of the deceased due to suicide, self-destruction or intentional self-inflicted injury?
If "Yes", please provide details. **Yes** ◯ **No** ◯

7) Was the cause of death due to accident? If "Yes", please provide details: **Yes** ◯ **No** ◯

(i) Date of Accident (ddmmyyyy)

(ii) Place of Accident

(iii) Please describe how the accident occurred and describe the injuries sustained by the deceased.

8) Please provide us with any other additional information that will enable the Company to assess this claim.

D) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (dd/mm/yyyy)	

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