Life Insurance

DEATH - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. **Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Deceased for illnesses / injuries sustained.**
2. **Expenses incurred to obtain this report will be borne by the Claimant.**

POLICY / CONTRACT NO: _____

1. Name of the Deceased in full	
2. NRIC / Old IC/ Other Identity No(Please Specify)	
3. Age	
4. Deceased's Address at time of death	
5. Occupation at the time of death	
6. Date of death	(dd/mm/yyyy)
7. Place of death	
8. Cause of death	
9. Disease or condition directly leading to death	
10. By whom was the disease or condition first diagnosed Please provide name and address of doctor.	
11. Was the Deceased/family informed of the diagnosis	☐ Yes ☐ No
12. When did the Deceased firstconsult you?	(dd/mm/yyyy)
13. Diagnosis at the first consultation	
14. In your opinion, how long Deceased experienced the sign or symptoms?	
15. Are you the Deceased's regular / family doctor?	☐ Yes ☐ No
16. If no, please give name and address of Deceased's regular doctor (if known)	
17. Was the Deceased referred to you by another doctor? If yes, please give name and address of the doctor	☐ Yes ☐ No
18. Did you attend to Deceased's last illness If no, please give name and address of the attending doctor	☐ Yes ☐ No
19. Was death due to self-infliction	☐ Yes ☐ No
IF DEATH DUE TO ACCIDENT, PLEASE GIVE DETAILS	
20. .Date and Time of accident	(dd/mm/yyyy)
21. How did the accident happen?	
22. Was the Deceased suspected to be under the influence of any alcohol or drug ?	☐ Yes ☐ No
23. If yes, was three any sample of urine or blood sent for further test?	☐ Yes - Result _____ ☐ No
24. In your opinion / investigation, do you think that death resulted from the accident?	☐ Yes ☐ No
25. Was there any predisposing cause directly or indirectly to Deceased's death?	☐ Habits use of tobacco, alcohol, narcotics ☐ Family History ☐ Occupation of Deceased ☐ HIV / AIDS

PAST MEDICAL HISTORY	
26. If the Deceased diagnosed of	**High Blood Pressure** Readings : _____mmHg Date : ____/____/_____ — Readings : _____mmHg Date : ____/____/_____ — **Diabetes** Readings : _____(RBS/FBS) Date : ____/____/____ —— — Readings : _____(RBS/FBS Date : ____/____/_____ —

DETAILS OF OTHER ATTENDING DOCTORS WHO HAD TREATED THE DECEASED IN THE LAST TWO YEARS

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Treatment given

27. Any further information which in your opinion will assist us in assessing the claim	

DECLARATION:

I, the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

Name of the Attending Physician	Signature of the Attending Physician	Official Stamp and Address of Hospital / Clinic :
Date (dd/mm/yyyy)	Contact No.	