eTiQa Life Insurance

STATEMENT OF MEDICAL EXAMINER – DEATH CLAIM

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 the injuries s/ illness sustain.
2. Expenses incurred to obtain this report will be borne by the Claimant / Next of Kin.

Policy no: ……

Name of deceased in full: ……

NRIC no. : …… Sex: ☐ Male ☐ Female Age: ……..

Date of Birth: …… Occupation at time: ……..

1. Date and Time of Death: …… 2. Place of Death: ……..……...

3. Cause of Death: ……

4. Are you the patient's regular doctor? ☐ Yes ☐ No

5. Since when have you known the deceased? ……

6. i) Date the patient first consulted you (dd/mm/yyyy) : ……..……..

ii) What was the diagnosis at the first consultation: ……

iii) According to the deceased, how long do you feel the deceased had the symptom: ……

iv) In your opinion, how long do you feel the deceased has the symptom; ……

7. i) Were you consulted by the deceased during his/her last illness? ☐ Yes ☐ No

ii) If not, please give the name and address of the attending doctor: ……..

8. If deceased was hospitalized, please state:

Admission Date: …… Discharge Date: …… Diagnosis: …….. Place: ……..

…… …… …….. ……..

…… …… …….. ……..

9. a) What was the immediate cause of death? Provide condition, injury or complication which directly leads to death:

……

b) When, where and by whom was the illness first diagnosed? Date: …… Place: …… By Whom: ……

c) Was Deceased/ family informed of the diagnosis? ☐ Yes ☐ No

10. a) If the primary cause of death differs from the immediate cause, please state the primary cause.……

……..……...

b) When and where it was first diagnosed? Date: …… Place: ……..

c) Was Deceased / family informed of the diagnosis? ☐ Yes ☐ No

d) Was the Deceased referred to you by other doctor? ☐ Yes ☐ No

Please state reason: …….. Please give name and address of the doctor: ……

11. Give details of any follow-up(s), or referral by / to other doctor(s), if any

Name & Address of Doctors / Hospital	Date of Attendance	Illness or condition consulted
……	……	……
……	……	……
……	……	……

12. Was death due to ☐ self-inflicted ☐ homicide ☐ accident ☐ suicide

Please give details ……

……..……...

13. If death due to accident, please give details:

i. Date of accident: …… (dd/mm/yyyy) Time.....(am/pm)

ii. How did the accident happen? ……

CERTIFICATE NO:

iii. Was the deceased suspected to be under the influence of any alcohol or drug? ☐ Yes ☐ No

If yes, was there any sample of urine or blood sent for further test? ☐ Yes ☐ No

iv. In your opinion / investigation, do you think that the death resulted from the accident? ☐ Yes ☐ No

14 Was there any predisposing cause directly or indirectly to Deceased death?

i. Habit use of tobacco, alcohol, narcotics ☐ Yes ☐ No

ii. Family History ☐ Yes ☐ No

iii. Occupation of Deceased ☐ Yes ☐ No

iv. HIV / AIDS ☐ Yes ☐ No

If 13 (iv) is yes, was the illness transmitted via blood transfusion? ☐ Yes ☐ No

15. Please state below from past records or from your personal knowledge details of all illnesses, accidents, treatments and/or surgical procedures performed for the diseases that deceased had suffered from in this hospital or any other hospitals.

Date of Onset / Diagnosed	Symptoms	Disease / Diagnosis	Treatment / Management	Name of Hospital / Clinics

16. Was an inquest or post-mortem examination held on the body? ☐ Yes ☐ No

If yes, please furnish certified copy of verdict or findings

If so, state which, by whom and the results …….

17. If the Deceased diagnosed to have High Blood Pressure and/ or Diabetes, please state the recorded blood pressure or diabetes taken on him / her starting from the **first** recording done:

	Date (dd/mm/yyyy)	Readings of Blood Pressure	Date (dd/mm/yyyy)	Result for Blood Glucose (fasting)
i.	……..	…… …	……...	……..
ii.	……...	…… …	……...	……...
iii.	……..	…… …	……...	……...

18. Details of other attending doctors who had treated the Deceased in the last **two** years

……...

19. Any further information which in your opinion will assist us in assessing the claim? ……

……..

20. **To attach photocopy of detailed medical history / medical card of the Deceased.**

CERTIFICATE NO:

DECLARATION

I, the attending physician do solemnly and sincerely declare that the foregoing answer and any additional information given by me at the bottom of this and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor: ……

Name of Doctor : ……

Qualification : ……

Telephone no : ……

Fax No : ……

Date : ……

Name and Address of Clinic / Hospital: ……

……

Official Stamp of Doctor:

……..

Hospital / Clinic Official Stamp

……..