(990190-v)
(INCORPORATED IN SINGAPORE)
40 - 44 Jalan Ampang, 50450 Kuala Lumpur
Claims Department Tel. No. : 2003768/2003788 Fax No. : 03-2387085

DOCTOR'S STATEMENT

Please fill in this form in your own hand writing. Kindly answer all questions completely as this will assist us to accurately, fairly and promptly assess the claim. Your co-operation is deeply appreciated. The cost of this certification is borne by the applicant.

1. Name of the Deceased (in full) : .....
2. NRIC No. : .....
3. Date of death : .....
4. Height : .....
5. Weight : .....

6. Was the Deceased hospitalised ? : ☐ Yes ☐ No If No, please ignore questions 7 - 8.

7. If yes, where was he/she hospitalised ? : .....
.....

8. Dates of first admission & last discharge : .....
.....

9. Name(s) of attending doctor(s) : .....
.....

10. When did the Deceased FIRST consult you ? : .....

11. What was the diagnosis of the consultation ? : .....
.....
.....
.....

12. Please give details of follow up(s), if any : .....
.....
or referral to other doctor(s), if any : .....
.....

13. Did you attend to Deceased's last illness : ☐ Yes ☐ No
14. If Yes, what was the diagnosis ? : .....
15. If not, please give the name and address of the attending doctor : .....
.....
.....

16. Are you the Deceased's regular/family doctor ? : ☐ Yes ☐ No If Yes, for how long ? .....
17. If not, please give details of his/her regular/ family doctor, if known. .....
.....
.....

18. Was the Deceased referred to you ? : ☐ Yes ☐ No
19. If Yes, please give the name and address of the attending doctor ? : .....
: .....
.....

19. CAUSE OF DEATH	Approximate interval between onset and d h			
	Years	Months	Days	Ho s
I) Disease or condition **DIRECTLY** leading to death : - a) _____ b) _____ Where & by whom was the disease diagnosed ? .... Was the Deceased/family informed of the diagnosis ? ☐ Yes ☐ No ☐ Information unavailable	.....	.....	.....	.....
II) ANTECEDENT causes : - a) _____ b) _____ Where & by whom was the disease diagnosed ? .... Was the Deceased/family informed of the diagnosis ? ☐ Yes ☐ No ☐ Information unavailable	.....	.....	.....	.....
III) Other significant conditions : -	.....	.....	.....	.....

20. Was there any special cause for the death, directly or indirectly in the HABITS (use of alcohol or drugs), OCCUPATIC or FAMILY history of the Deceased ? ☐ No ☐ Yes

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.....
..... (please detai

21. Please briefly detail the Deceased's medical history.

Disease	Date of diagnosis	Dates of treatment

22. Details of other attending doctors who had treated the Deceased in the last two year : .....
.....
.....

23. Any other information you feel may be relevant .....
.....
.....

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

Signature : .....
Name : .....
Qualification : .....
Tel. No. : .....

Date : .....
Address : .....
.....
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