



DEATH CLAIM – DOCTOR'S STATEMENT

DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

Deceased's particulars	
1) Name of Deceased	
2) NRIC/FIN or Passport No.	3) Date of Birth (ddmmyyyy)
4) Name of the Deceased's Company	5) Occupation

Details of Death	
1) Date of Death (ddmmyyyy)	2) Place of Death
3) What was the Final Cause of Death?	
4) How long has the illness been existing prior to Death?	
5) Did the Deceased have any symptoms prior to Death? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state symptoms presented and date symptoms First appeared. i) Date symptoms First started (ddmmyyyy): ii) Please describe the symptom(s) First presented. iii) When did the Deceased First consult you for this condition? (ddmmyyyy) iv) Date of treatment rendered (ddmmyyyy): v) Nature of treatment rendered:	
6) What is the source of this information? Please specify the name of the person and his/her relationship to the Deceased.	
7) When was the condition leading to the cause of Death First diagnosed? (ddmmyyyy)	
8) Was the Deceased informed of the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when was the Deceased First informed? (ddmmyyyy)	

9) Was there any predisposing cause of the Deceased's death in his/her habits (e.g. use of alcohol, narcotics, etc.), family history, occupation or previous sickness? If "Yes", please provide details, including the date of commencement and source of information.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10) Was the cause of death solely due to bodily injury caused by an accident? If "Yes", please provide details:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of accident (ddmmyyyy)			
Place of accident			
Please describe how the accident occurred			
Please describe the nature and extent of injuries sustained			
11) What was the bodily injury sustained?			
12) Was the bodily injury caused by the mentioned Accident above directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?			
i)	The influence of alcohol voluntarily or involuntarily? If "Yes", please state blood alcohol concentration level:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ii)	The influence of drugs or Intoxication, voluntarily or involuntarily? If "Yes", please state name of drugs and quantity of drugs consumed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii)	The taking of poison or inhalation of gas, voluntarily or involuntarily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iv)	The use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
v)	Bodily infirmity, mental, psychiatric, anxiety, nervous disorders, sleep disturbance disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
vi)	Birth defects, including hereditary conditions or congenital anomalies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
vii)	Childbirth, pregnancy, and complications thereof?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
viii)	Any form of dental care or surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ix)	Treatment for obesity, weight management program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
x)	Treatment for infertility, contraception, sterilisation, impotence, sexual dysfunction or assisted conception tests or sex change operations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xi)	Any elective surgery, cosmetic or plastic surgery not necessitated by injury or illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xii)	Any infection other than an infection occurring simultaneously with and in consequence of a cut or wound of an Accidental Injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xiii)	Human Immunodeficiency Virus infection, AIDS, or any sexually transmitted disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xiv)	Self-inflicted injury, while sane or insane?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xv)	Suicide, attempted suicide, while sane or insane?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

xvi)	Engagement or involvement in hazardous activity (e.g. aerial activity, rock climbing, mountaineering, underwater activities, bungee-jumping, martial arts activities, boxing, etc)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xvii)	Engagement or involvement in sports on a professional or competitive basis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xviii)	Injuries sustained during travel in or on any type of aircraft?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xix)	Committing, attempting, or provoking an assault or a felony or any violation of the law?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
xx)	Treatment of an experimental, investigational, research, preventive or screening nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If any of the conditions listed in Question 12 (i) to (xx) above is are answered as "Yes", please provide details:			

Deceased's Medical records			
1) Did the Deceased suffer from any other illness(es)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please advise:			
Name & Address of Doctor	Date of Diagnosis (ddmmyyyy)	Illness	Date & Type of Treatment
2) Did the Deceased consult any other doctor(s) before consulting you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please provide details, including the name(s) and address(es) of doctor(s) and reason(s) for consultation.			

Other information
1) Please provide us with any other additional information that may assist the Company in assessing this claim.
<p>Please enclose copies of all investigation reports including specialist, hospital and laboratory reports that are available. Where applicable, please include the following:</p> <ul style="list-style-type: none"> (i) Computerised tomography scan (CT scan) (ii) Magnetic resonance imaging (MRI), other imaging studies (iii) X-Ray (iv) Operation reports, surgical reports (v) Referral letters (if any) (vi) Any other investigation reports

Declaration

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

Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)