Claim No.: _____

## MEDICAL ATTENDANT'S REPORT ON DEATH CLAIM

This report is to be completed by the registered medical practitioner at the own expense of Next-Of-Kin / Claimant.

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| 1. a) Name of Deceased.<br>b) I/C No.<br>c) Date of Birth.<br>d) Present Occupation. (If more than one, please state all)<br>e) Takaful Certificate No. | a)<br>b) Old: New:<br>c)<br>d)<br>e) |
| 2. a) Date of death.<br>b) Time.<br>c) Place of death.<br>d) Primary cause of death.<br>e) Secondary cause of death. | a)<br>b) AM PM<br>c)<br>d)<br>e) |
| 3. a) Were you the deceased's usual medical physician? Since when?<br>b) If so, please state his / her first date of consultation with you.<br>c) Please state date when deceased first consulted you in respect of the illness related to his / her death.<br>d) Were you present at the time of death? If 'No', on what date did you last attend to the deceased and for what illness. | a) DD MM YYYY _____ / _____ /_____<br>b) DD MM YYYY _____ / _____ /_____<br>c) DD MM YYYY _____ / _____ /_____<br>d) DD MM YYYY _____ / _____ /_____ |

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| 4. a) | How long had the deceased been suffering from the condition for the primary cause of his / her death? (Please state the duration). | a) Month _____ Years _____ |
| b) | What were the symptoms presented? | b) DD MM YYYY _____ / _____ /_____ |
| c) | Date when symptoms first appeared. | c) DD MM YYYY _____ / _____ /_____ |
| d) | Date when deceased was first treated for this condition. | d) DD MM YYYY _____ / _____ /_____ |
| e) | Diagnosis established. | e) |
| f) | Date of diagnosis. | f) DD MM YYYY _____ / _____ /_____ |
| g) | Name and address of doctor who established the diagnosis. | g) |
| h) | Date when the diagnosis was first told to deceased. | h) DD MM YYYY _____ / _____ /_____ |
| i) | Name and address of referral doctor. | i) |
| j) | Name(s) and address(es) of all doctor(s) attended to the deceased for this condition. | j) |
| 5. a) | How long had the deceased been suffering from the condition for secondary cause of his / her death? (Please state the duration). | a) Month _____ Years _____ |
| b) | Date when deceased was first treated for this condition. | b) DD MM YYYY _____ / _____ /_____ |
| c) | Diagnosis established. | c) |
| d) | Date of diagnosis. | d) DD MM YYYY _____ / _____ /_____ |
| e) | Name and address of doctor who established the diagnosis. | e) |
| f) | Date when diagnosis was first told to deceased. | f) DD MM YYYY _____ / _____ /_____ |
| g) | Names and addresses of all doctors attended to the deceased for this condition. | g) |

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| 6. a) Was deceased's death attributable directly to complication of childbirth? | a) |
| b) Please state the date of delivery. | b) DD MM YYYY<br>_____ / _____ /_____ |
| c) Please state the duration of pregnancy (in days or weeks) at date of deceased's death. | c) Week (s) Month<br>_____ _____ |
| d) Did death occur during the first 168 days of pregnancy? | d) |
| 7. Please give details of your patient's smoking habits, both past and present. | |
| a) Does the patient smoke? | a) |
| i) If "Yes", how many sticks does the patient smoke in a day? | i) |
| ii) What is the exact duration? | ii) |
| b) If "No", is the patient a non-smoker? | b) |
| c) If he was a smoker in the past, then when did the patient stop smoking? | c) |
| 8. a) Was deceased's death due to accident? | a) |
| b) Was deceased's death due to attempted suicide or suicide / self –inflicted injury? | b) |
| c) Was there any predisposing cause of deceased's death such as his/her habit as below:- if any, please specify and provide details and date of first occurrence. | c) |
| i) Use of drugs / alcohol and etc. | i) |
| ii) Family History. | ii) |
| iii) Occupation. | iii) |
| iv) Previous sickness. | iv) |
| v) Participating in any hobby, avocation or hazardous pursuit. | v) |

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| 9. Was an inquest performed? If yes, please attach a certified true copy. | |

| 10. Has the patient ever been diagnosed / suffered from any of the following: | Diagnosis | Date of Diagnosis / Onset | Name and Address of Doctor(s) Consulted | Dates of Treatment Consulted (DD/MYYYY) |
|---|---|---|---|---|
| a) Hypertension. | a) | | | |
| b) Diabetes Mellitus. | b) | | | |
| c) Cardiovascular Disease. | c) | | | |
| d) Other Illness (es) / Injuries. | d) | | | |
| If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation. | | | | |

| 11. Any other information relevant to the death which may be of assistance to us in assessing this claim. | |
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We would be most grateful if you could send copies of any specialist or hospital reports, together with any test, reading, or similar evidence to support the validity of your patient's claim.

Office Stamp:

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____

For Office Use Only

Checked and Verified By: _____ Date: _____ Branch: _____
(Name of Staff)