Manulife

DEATH CLAIM - ATTENDING PHYSICIAN'S STATEMENT
(This form to be completed by deceased's last attending doctor at claimant's own cost)

Deceased's Personal Details

Policy No.	1)
	2)
	3)
	4)
Name of Deceased	
New NRIC/ old IC No.	
Date of Birth	
Gender	

A DECEASED'S MEDICAL RECORD

Height, Weight, Date of Measurement	**Height** ..... **cm** **Weight** ..... **kg** **Date** ..... /..... /..... **(DD/***HH***)** **(MM/***BB***)** **(YYYY/***TTTT***)**
Date & Time of Death	
Place of Death	
Please provide details for cause of death: **i. First symptom onset date** **ii. Diagnosis date** **iii. Cause of death** **iv. Underlying cause**	_____ _____ _____ _____
Did you attend deceased during his/her last illness? **If Yes, please provide following:**	☐ **Yes** ☐ **No**

Date of consultation	Presenting symptom & duration	Diagnosis	Treatment Given

Was other doctor referring deceased to you? **if Yes, please state the name(s) and address(es) of the attending doctor(s) & enclosed a copy of referral letter**	☐ **Yes** ☐ **No**
Are you the Deceased's regular/family doctor? **If yes, since what date? If No, please provide name & address of deceased's regular/family doctor for past three years.**	☐ **Yes** ☐ **No**

Version 052023

A DECEASED'S MEDICAL RECORD

Has deceased been previously treated at you hosp/clinic or any healthcare facility for any other medical condition for past 3 years?

If Yes, please provide following:

☐ **Yes** ☐ **No**

Date of consultation	Presenting symptom & duration	Diagnosis	Treatment Given	Name of Treating Doctor	Name of Clinic	Hosp Address

Was deceased hospitalised in past three years?

If Yes, please provide details:

☐ **Yes** ☐ **No**

Date of admission	Name of Hospital	Name of Attending Doctor	Admitting Diagnosis

Please provide the following if cause of death due to accident:

i. Date & time of accident

ii. Place of Accident

iii. Describe how is accident happen

Was an inquest or post-mortem examination held on the body?

If Yes, please furnish a copy of the said report.

☐ **Yes** ☐ **No**

Is the cause of death related to any of the followings?

If yes, please tick.

☐ **Yes** ☐ **No**

- ☐ **AIDS/ HIV positive**
- ☐ **Influence of Drugs/ Alcohol**
- ☐ **Family history**
- ☐ **Professional sports/ hazardous sport activities**
- ☐ **Suicide**
- ☐ **Violation of laws/ strike/ riots**
- ☐ **Occupation**

Any other information that you feel may be relevant in assisting us for claim processing?

B ATTENDING DOCTOR'S DECLARATION

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

Signature of doctor

Name & practice stamp

Name & address of clinic/hospital

Date

Version 052023