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:**<br>**i. First symptom onset date**<br>**ii. Diagnosis date**<br>**iii. Cause of death**<br>**iv. Underlying cause** | _____<br>_____<br>_____<br>_____ |
| **Did you attend deceased during his/her last illness?**<br>**If Yes, please provide following:** | ☐ **Yes** ☐ **No** |

| Date of consultation | Presenting symptom & duration | Diagnosis | Treatment Given |
|---|---|---|---|
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|---|---|
| **Was other doctor referring deceased to you?**<br>**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?**<br>**If yes, since what date? If No, please provide name & address of deceased's regular/family doctor for past three years.** | ☐ **Yes** ☐ **No** |

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# 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 |
|---|---|---|---|---|---|---|
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**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 |
|---|---|---|---|
| | | | |
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**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**

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