HongLeong Assurance

C002109110

Policy No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DEATH CLAIM

This report is to be completed by a registered medical practitioner at the own expense of claimant.

1. a) Name of deceased.		
b) I/C No.		
c) Date of Birth.	Date: (dd/mm/yyyy)	
d) Present Occupation. (If more than one, please state all)		
2. a) Date and time of death.	Date: (dd/mm/yyyy) Time: (am/pm)	
b) Place of death.		
3. Please answer the questions below in respect of the primary and secondary cause of patient's death.	Primary Cause	Secondary Cause
a) Cause of death / diagnosis.		
b) How long had the deceased been suffering from the condition (please state the duration)?		
c) Symptoms presented at that time.		
d) Date of symptoms first appeared.	Date: (dd/mm/yyyy)	Date: (dd/mm/yyyy)
e) Date when the deceased was first treated for the condition.	Date: (dd/mm/yyyy)	Date: (dd/mm/yyyy)
f) Date of diagnosis.	Date: (dd/mm/yyyy)	Date: (dd/mm/yyyy)
g) Name and address of doctor who established the diagnosis.		
h) Date when diagnosis was first told to deceased.	Date: (dd/mm/yyyy)	Date: (dd/mm/yyyy)
i) Name and address of referral doctor.		
j) Name and address of all doctor(s) attended to the deceased for the condition.		
4. a) Were you the deceased's usual medical physician?	Yes ☐ No ☐	
b) If yes, please state the deceased's first date of consultation with you.	Date: (dd/mm/yyyy)	
c) Date when deceased first consulted you in respect of the illness related to his / her death.	Date: (dd/mm/yyyy)	
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?	Yes ☐ No ☐ i. Date last attended to the deceased : _____(dd/mm/yyyy) ii. Illness : _____	

5. a) Was the deceased's death due to accident?	Yes ☐ No ☐
b) Was the deceased's death due to attempted suicide or suicide / self-inflicted injury?	Yes ☐ No ☐
c) Did the use of drugs or alcohol contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	Yes ☐ No ☐ Date: (dd/mm/yyyy) Details:
d) Did any of the deceased's previous sickness contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	Yes ☐ No ☐ Date: (dd/mm/yyyy) Details:
e) Did any of the deceased's hobby, participation in avocation or hazardous pursuit contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	Yes ☐ No ☐ Date: (dd/mm/yyyy) Details:
6. Was an inquest or post-mortem performed? If yes, please enclose an original sighted copy of the report.	Yes ☐ No ☐
7. Please complete the section below if the cause of death was due to childbirth.	
a) Was the deceased's death attributable directly to complication of childbirth?	Yes ☐ No ☐
b) Please state the date of delivery.	Date: (dd/mm/yyyy)
c) Please state the duration of pregnancy (in days or weeks) at date of deceased's death.	

8. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Dates of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses / Injuries Please specify: i. ii.	 i. ii.	 i. ii.	 i. ii.

9. Please give other information which you feel would be helpful in the assessment of your patient's claim.	

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Contact No.: _____

Date: _____(dd/mm/yyyy)

Official Stamp: