DEATH CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed by the deceased's last Attending Physician/ Surgeon at Claimant's expense.



Deceased's Personal Details							
Name					Policy Number		
NRIC/Old IC/Passport/Birth Cert/Others	Date	of Birth			Gender		
					Male	Female	
Section A: Deceased's Medical Reco	rd						
1. Height Weight	Date Measured						
CM KG	Day	Ν	Month	Year			
2. Date & Time of Death							
Day Month	h Ye	ear	am/pm				
3. Place of Death							
4. Please provide the details for cause of	death						
i. First symptom onset date			Month	Veer			
	Day			Year			
ii. Diagnosis date	Day	Ν	Month	Year			
iii. Cause of death							
iv. Underlying cause							
5.) during	the deceased's						
5.) during	the deceased's						
YES NO					1	Turcharout	
YES NO If ', please Date of Consultation Prese	the deceased's inting Symptom nd Duration		Diagnosis			Treatment Administered	
YES NO If ' , please Date of Consultation Prese	nting Symptom		Diagnosis				
YES NO If ' , please Date of Consultation Prese	nting Symptom		Diagnosis				
YES NO If ' , please Date of Consultation Prese	nting Symptom		Diagnosis				
YES NO If ' , please Date of Consultation Prese	nting Symptom nd Duration	an accident.	Diagnosis				
YES NO If ' , please Date of Consultation (DD/MM/YYYY) an	nting Symptom nd Duration		Diagnosis	De	etails of Accident	Administered	
YES NO If ' , please Prese Date of Consultation (DD/MM/YYYY) Prese 6. Please complete the following if the car	nting Symptom nd Duration use of death is due to		Diagnosis	De	etails of Accident	Administered	
YES NO If ' , please Prese Date of Consultation (DD/MM/YYYY) Prese 6. Please complete the following if the car	nting Symptom nd Duration use of death is due to		Diagnosis	De	etails of Accident	Administered	
YES NO If ' , please If ' , please Date of Consultation (DD/MM/YYYY) Prese (DD/MM/YYYY) 6. Please complete the following if the car Date & Time of Accident Date & Time of Accident 7. Was an inquest or post-mortem examination	enting Symptom nd Duration use of death is due to Place of Accio	lent				Administered	
YES NO If ' , please Prese Date of Consultation (DD/MM/YYYY) Prese at Attribute 6. Please complete the following if the car Date & Time of Accident	nting Symptom nd Duration use of death is due to Place of Accie nation held on the bo	dent dy? <i>If YES, please</i>				Administered	
YES NO If ' , please If ' , please Date of Consultation (DD/MM/YYYY) Prese (DD/MM/YYYY) and Image: Complete the following if the card of	nting Symptom nd Duration use of death is due to Place of Accie nation held on the bo	lent	e furnish certified co	ppy of verdi	ct/ findings/ post	Administered	
YES NO If ' , please Date of Consultation (DD/MM/YYYY) If ' , please Prese (DD/MM/YYY) If ' , please Prese (DD/M/YYY)	nting Symptom nd Duration use of death is due to Place of Accie nation held on the bo	dent dy? <i>If YES, please</i>	e furnish certified co	ppy of verdi nal sports/	ct/ findings/ post	Administered	
YES NO If ' , please Date of Consultation (DD/MM/YYYY) If ' , please (DD/MM/YYYY) If ' , please 0 (DD/MM/YYYY) If ' , please 0 <td>nting Symptom nd Duration use of death is due to Place of Accio nation held on the bo</td> <td>dent dy? <i>If YES, please</i> please tick [√].[~]</td> <td>e furnish certified co</td> <td>ppy of verdi</td> <td>ct/ findings/ post</td> <td>Administered</td> <td></td>	nting Symptom nd Duration use of death is due to Place of Accio nation held on the bo	dent dy? <i>If YES, please</i> please tick [√]. [~]	e furnish certified co	ppy of verdi	ct/ findings/ post	Administered	
YES NO If ' , please Date of Consultation (DD/MM/YYYY) If ' , please Prese (DD/MM/YYY) If ' , please Prese (DD/M/YYY)	nting Symptom nd Duration use of death is due to Place of Accio nation held on the bo	dent dy? <i>If YES, please</i> please tick [√]. [~]	e furnish certified co	ppy of verdi nal sports/	ct/ findings/ post	Administered	
YES NO If ' , please Date of Consultation (DD/MM/YYYY) Date of Consultation (DD/MM/YYYY) Prese (DD/MM/YYYY) 6. Please complete the following if the care Date & Time of Accident Date & Time of Accident YES NO 8. @ AIDS/ HIV positive Influence of Drugs/ Alcohol Insect bite 9. Please complete the following if the detail	nation held on the bo	dent dy? <i>If YES, please</i> please tick [√]. [~]	e furnish certified co	ppy of verdi nal sports/	ct/ findings/ post	Administered	
YES NO If ' , please Prese Date of Consultation (DD/MM/YYYY) Prese at Image: Consultation of the case 6. Please complete the following if the case Image: Consultation of the case Date & Time of Accident Image: Consultation of the case 7. Was an inquest or post-mortem examine YES YES NO 8. @ AIDS/ HIV positive Influence of Drugs/ Alcohol Insect bite 9. Please complete the following if the decase a. Gestation period (for Foetus)	nation held on the bo	dy? <i>If YES, please</i> olease tick [✓] . ⁻ tus: eeks / Months	e furnish certified co Professio Suicide Violation	ppy of verdi nal sports/	ct/ findings/ post	Administered	
YES NO If ' , please Date of Consultation (DD/MM/YYYY) Date of Consultation (DD/MM/YYYY) Prese (DD/MM/YYYY) 6. Please complete the following if the care Date & Time of Accident Date & Time of Accident YES NO 8. @ AIDS/ HIV positive Influence of Drugs/ Alcohol Insect bite 9. Please complete the following if the detail	nation held on the bo	dy? <i>If YES, please</i> olease tick [✓] . [•] tus: eeks / Months g? If yes, please t	e furnish certified co Suicide Violation	opy of verdi nal sports/ of laws/ Str	ct/findings/post Sporting activitie: rike/ Riots	Administered	

FORM ID 11601010	Prudential Assurance Malaysia Berhad 198301012262 (107655-U)			
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	P.O. Box 10025, 50700 Kuala Lumpur Tel (603) 2778 3888 www.prudential.com.my			
	Customer Service Tel (603) 2771 0228			

10. Has the deceased been	previously treated at you	r hospital/ clinic or any health	ncare facility(ies	s) for this o	or any other medical cond	lition for the past three years
YES	NO					
If Yes, please provide de	etails as required below :					
Date of Consultation (DD/MM/YYYY)	Presenting Symptom & Duration	Diagnosis	Diagnosis (DD/MM/)	Date YYYY)	Investigation Result	Treatment Administered
11. Was the deceased hosp	italised in the past three	years?				
YES	NO					
If ' , please	_					
Date of Admissio		Name of Hospital			Name of Attendi	ng Doctor
(DD/MM/YYYY)	(DD/MM/YYYY)					
12. Were you the deceased	_					
YES	NO					
If No, please provide th	e name of the	e deceased's regular/ family o	loctor for the pa	ast three y	ears.	
Name & Address of R	egular/ Family Doctor					
13. Was the deceased refe	erred to you?					
YES	NO					
If Yes, please provide o	 details below and enclose	a copy of the referral letter (i	fany).			
Name & Address of R			,,			
Name & Address of A						
SECTION B : Attending	Doctor's Declaration					
I hereby certify that:						
	attending doctor and I ha	ave personally examined and	treated the dec	eased for	the illnesses/ iniuries sus	tained: OR
	erused the deceased's me				· · · · · · · · · · · · · · · · · · ·	
and that the facts as stat	ed above are all true to th	e best of my knowledge and	information tha	at I have pe	erused.	
Signature	:		Da	ate :		
Name	:					
Professional Qualification	ı :					
MMC/ Registration Numl	ber :					
Name & Address of Hosp	ital/ Clinic :					
Official Stamp of the Doc	tor :					

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