DEATH CLAIM - DOCTOR'S STATEMENT

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

PRUDENTIAL

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 Record

1. Height ☐ CM Weight ☐ KG Date Measured ☐ Day ☐ Month ☐ Year

2. Date & Time of Death

☐ Day ☐ Month ☐ Year ☐ am/pm

3. Place of Death

4. Please provide the details for cause of death.

i. First symptom onset date ☐ Day ☐ Month ☐ Year

ii. Diagnosis date ☐ Day ☐ Month ☐ Year

iii. Cause of death

iv. Underlying cause

5. 5ιŘ è2ͼ l·ǘǘŜyŘ ǘ2 ǘKŜ ŘŜǑŜl·ăŜŘ during the deceased's fl·ăǘ λffyŜăǎK

☐ YES ☐ NO

If ¸Ŝă, please ǈǊ2ǾιŘŜ ŘŜǘl·λfăφ

Date of Consultation (DD/MM/YYYY)	Presenting Symptom and Duration	Diagnosis	Treatment Administered

6. Please complete the following if the cause of death is due to an accident.

Date & Time of Accident	Place of Accident	Details of Accident

7. Was an inquest or post-mortem examination held on the body? ***If YES, please furnish certified copy of verdict/ findings/ post-mortem report.***

☐ YES ☐ NO

8. Lă ǘKŜ Ŏl·ͼăŜ 2Ŧ ŘŜl·ǘK ǋŜfl·ǘŜŘ ǘ2 l·yè 2Ŧ ǘKŜ Ŧ2ff2ǿιy∃K If yes, please tick [✓] .

☐ AIDS/ HIV positive
☐ Influence of Drugs/ Alcohol
☐ Insect bite
☐ Professional sports/ Sporting activities
☐ Suicide
☐ Violation of laws/ Strike/ Riots

9. Please complete the following if the deceased is a Child/ Foetus:

a. Gestation period (for Foetus)

☐ Weeks / Months

b. Is the death of foetus/ child related to any of the following? If yes, please tick [✓].

☐ Elective termination of pregnancy other than for medical reasons
☐ Complication resulting from fertility treatment including in vitro fertilisation

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10. Has the deceased been previously treated at your hospital/ clinic or any healthcare facility(ies) for this or any other medical condition for the past three years?

☐ YES ☐ NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Presenting Symptom & Duration	Diagnosis	Diagnosis Date (DD/MM/YYYY)	Investigation Result	Treatment Administered

11. Was the deceased hospitalised in the past three years?

☐ YES ☐ NO

If ¸Ŝă, please ǈǋ2ǾλŘŜ ŘŜǘl·λfăφ

Date of Admission (DD/MM/YYYY)	Name of Hospital	Name of Attending Doctor

12. Were you the deceased's regular/ family doctor?

☐ YES ☐ NO

If No, please provide the name l·yŘ l·ŘŘǋŜăă of the deceased's regular/ family doctor for the past three years.

Name & Address of Regular/ Family Doctor

13. Was the deceased referred to you?

☐ YES ☐ NO

If Yes, please provide details below and enclose a copy of the referral letter (if any).

Name & Address of Referral Doctor

SECTION B : Attending Doctor's Declaration

I hereby certify that:

☐ I am the deceased's attending doctor and I have personally examined and treated the deceased for the illnesses/ injuries sustained; OR

☐ I have personally perused the deceased's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :