

2. a. Date of death: _____
 b. Place of death: _____
 c. Cause of death: _____
3. To the best of your knowledge, please give names and address of all other physicians who attended the deceased during the past three years.

Date (day/month/year)	Disease/ Disorder	Details of Treatment/Hospitalization	Name and address of the physicians

4. Was there any medical condition in any way contributed or predisposed to the cause of death? If “yes”, please provide details.

5. a. Did the deceased have any habit of smoking, alcohol drinking or taking drugs? Yes No
- b. Did the deceased suffer any illness which predispose to cause the death, in the past? Yes No
- c. Did the deceased have any family history which predispose to cause the death? Yes No
- d. Was the death related to self-inflicted behavior? Yes No
- For Females Only:*
- e. Was the death related to pregnancy or complication of pregnancy? Yes No
- For any “yes” answer, please state the question number and give details

6. Was there any post-mortem examination done in the deceased’s body? Yes No
- If “yes”, please give a copy of the report
7. Do you consent insurance company and/or claim assessor to release the information provided by you in this report to the deceased’s family and/or claimant(s) when we are requested by the deceased’s family and/or claimant(s), to explain our claim decision Yes No

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.

Name of Attending Physician: _____ Signature (with stamp): _____
 Qualification: _____ Date (day/month/year): _____
 Tel: _____
 Fax: _____
 Email: _____