ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIM

PACIFIC CROSS

Please print in BLOCK Letters

(to be completed by the deceased's last attending physician without expenses to insurance company)

Name of Policyholder: _____ Policy No.: _____

Name of Deceased: _____ Member No.: _____

Sex: _____ Age: _____ Date of Birth (day/month/year): _____ Passport/ I.D.No.: _____

Residence at the time of death: _____

Occupation prior to death: _____

1. a. Were you the last attending physician of the deceased? If not, please give details of the last attending physician?

_____

_____

b. Date on which you first saw the deceased?

_____

_____

c. Who referred the deceased to you? Please indicate his/her full name and address

_____

_____

d. How long have you acquainted with the deceased?

_____

_____

e. Please give particulars of any illnesses or investigations for which he/ she has consulted you:

Date Attended (day/month/year)	Complaints & Abnormal Physical Findings	Duration of Illness	Diagnosis	Describe Treatment (including name of drugs prescribed) or Operation

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: _____