DEATH CLAIM FORM - DOCTOR STATEMENT

Certificate No. | New NRIC No. - -
Certificate No. | Old NRIC/Birth Certificate/ Passport No.
Certificate No. | Name of Deceased
Certificate No.

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted for Death benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any fee incurred in completing this form, it will be borne by claimant)

SECTION I: DECEASED'S MEDICAL RECORD

1. Date of Death — / / (dd/mm/yyyy)

2. Height / Weight — _____ (cm) _____ (kg)

3. Are you the Deceased's regular / family doctor? ☐ Yes ☐ No
If "YES", since what date? / / (dd/mm/yyyy)

4. Has the Deceased previously suffered from or been detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?
☐ Yes ☐ No

If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name of Clinic / Hospital and Address

5. Did you attend to the Deceased's last illness? ☐ Yes ☐ No
If "YES",
(i) What were the symptoms presented? (i) _____
(ii) Date of symptoms started (ii) / / (dd/mm/yyyy)
(iii) What was the diagnosis? (iii) _____

6. Was the Deceased hospitalised? ☐ Yes ☐ No
If "YES", please state the:
(i) Name of hospital admitted (i) _____
(ii) Date of First admission (ii) / / (dd/mm/yyyy)
Date of Last admission / / (dd/mm/yyyy)
(iii) Name(s) of attending doctor(s) (iii) _____

7. Was other doctor referring the Deceased to you? ☐ Yes ☐ No
If "YES", please state the name(s) and address(es) of the attending doctor(s)

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8. (i) Please state the disease(s) or condition(s) DIRECTLY leading to death with approximate interval between onset and death.

Cause of Death	Approximate Interval between onset and death			
	Years	Months	Days	Hours

(ii) Name of doctor(s) and hospital(s) that made the diagnosis.

(iii) Was the Deceased / family been informed of the diagnosis?

☐ Yes ☐ No ☐ Information unavailable

9. Was there any predisposing cause(s) of the Deceased's death in his/her habits (use of alcohol, narcotics, etc), family history, occupation or previous sickness?

☐ Yes ☐ No

If "YES", please provide details:

10. Any other information that you feel may be relevant?

SECTION II: This section is applicable to <u>ACCIDENTAL DEATH</u> only

Please attach certified true copies of ALL the relevant laboratory evidences / tests available

☐ Post-mortem or Autopsy report ☐ Alcohol / drug test report

1. Date and Time of Accident: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ☐☐ - ☐☐ (am/pm)

2. Nature of Accident (please tick only one)

☐ Road Traffic Accident ☐ Fall from Height / Building
☐ Drowning ☐ Industrial / Accident at Work
☐ Fire ☐ Air / Rail / Ship Disaster
☐ Explosion ☐ Sports Related
☐ Other: Please describe:

3. Please describe how the accident happen.

4. Was the Deceased suspected to be under the influence of any alcohol or drugs?

☐ Yes ☐ No

If "YES", was there any sample of urine or blood sent for further test?

☐ Yes ☐ No

5. In your opinion / investigation, do you think that death was resulted from the accident?

☐ Yes ☐ No

If "NO", what do you think was the cause of death? Please elaborate in detail.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, do hereby declare that I have answered the above questions are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name:

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)