FWD takaful

DEATH CLAIM FORM
BORANG TUNTUTAN KEMATIAN

PART 2 - STATEMENT BY PHYSICIAN

A. To be completed by the Physician who last attended to the Deceased
B. Expenses incurred to obtain this report will be borne by the Claimant / Next of Kin(s)

Name of Deceased			
Age		NRIC (New)	
Present Occupation		Gender	☐ Male / ☐ Female

1. i) General Details	
a) Date and time of death	Date : (dd/mm/yy) Time : am / pm
b) Place of death	
c) Please answer the questions below in respect of the primary cause of patient's death. i. Cause of death / diagnosis	
ii. How long had the deceased been suffering from this condition (please state the duration)	
iii. Symptoms presented at that time	
iv. Date of symptoms first appeared	
v. Date when the deceased was first treated for this condition	
vi. Date of diagnosis	
vii. Name and address of doctor who established the diagnosis	
viii. Was your patient informed of the diagnosis? If yes, when and by whom?	

ix. Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details, including exact date of episodes or conditions.	
x. Was your patient referred to you? If yes, please give name and address of doctor concerned.	
xi. Name and address of doctor(s) who attended to your patient prior to seeing you	
xii. Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
xiii. Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	According to patient :____________________________________ In your opinion :____________________________________
xiv. Date last seen by you	
xv. Please describe the exact details of your patient's condition last seen by you	
d) Were you the deceased's usual medical physician?	☐ Yes ☐ No
e) If yes, please state the deceased's first date of consultation with you	
f) Date when deceased first consulted you in respect of the illness related to his/ her death	
g) Were you present at the time of death? If no, on what date did you last attend to the deceased and for what illness?	☐ Yes ☐ No i. Date last attended to the deceased : _______________________________ ii. Illness : _________________________

2. ii) Is there any secondary / underlying cause resulted to deceased's primary cause of death? If yes, please answer the questions below in respect of the secondary cause of patient's death.	
a) Cause of death / diagnosis?	
b) How long had the deceased been suffering from this condition (please state the duration)	
c) Symptoms presented at that time	

d) Date of symptoms first appeared	
e) Date when the deceased was first treated for this condition	
f) Date of diagnosis	
g) Name and address of doctor who established the diagnosis	
h) Was your patient informed of the diagnosis? If yes, when and by whom?	

3. Death Details	
a) Was the deceased's death due to accident?	☐ Yes ☐ No
b) Was the deceased's death due to attempted suicide or suicide / self-inflicted injury?	☐ Yes ☐ No
c) Did the use of drugs or alcohol contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	☐ Yes ☐ No Date and details：
d) Did any of the deceased's previous sickness contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	☐ Yes ☐ No Date and details：
e) Did any of the deceased's hobby, participation in avocation or hazardous pursuit contribute to the death of the deceased? If yes, kindly provide details and date of first occurrence.	☐ Yes ☐ No Date and details：
f) Was an inquest or post-mortem performed? If yes, please enclose a certified true copy of the report.	☐ Yes ☐ No
g) Were there any predisposing cause(s) of the deceased's death in relation to his habits (use of alcohol, narcotics, etc), family history, occupation or previous illness?	☐ Yes ☐ No

4. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.			
	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation
Hypertension			
Diabetes Mellitus			
Cardiovascular Diseases			
Other illnesses/ Injuries Please specify			
Other illnesses/ Injuries Please specify			

5. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Note: Please enclose copies of all investigation reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

____
(Signature of Doctor)

Name : _______________________________________

Qualification : ____

Date : _______________________________________

Official Hospital Stamp: