DEATH CLAIM
ATTENDING PHYSICIAN'S MEDICAL REPORT

FWD insurance BSN

Policy No.: ____________________

Name of Life Assured (Deceased): ____________________ **Age :** ________

NRIC No. / Birth Cert / Passport No.: ____________________ **Gender :** ☐ Male ☐ Female

INFORMATION ON DEATH AND MEDICAL HISTORY	
1. Are you the deceased's usual medical physician?	☐ Yes ☐ No
a) Date of FIRST consultation	a) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)
b) Please state the reason for the FIRST consultation.	b)
c) What were the symptoms complained of?	c)
d) How long had the Deceased been experiencing these symptoms prior to consulting you?	d)
2. Did you attend to the Deceased during his/her last illness?	☐ Yes ☐ No
a) If "Yes", what was the disease / medical condition?	a)
b) Date that Deceased was informed of the disease	b) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)
c) If "No", on what date did you last attend to the deceased? Please state the medical condition	c) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)
3. Was the Deceased referred to you by any other doctor?	☐ Yes ☐ No
a) If "Yes", please state the name, address & contact no. of the doctor who referred the Deceased to you	a)
b) Please attach a copy of referral letter	b)
4. Please state the cause of death	
5. What were the underlying cause and / or intervening cause leading to the death?	
6. What were the other contributing causes of death? Please give as near as you can on the duration of each cause.	
7. What were the other significant disease the Deceased had suffered and for how long?	
8. Was the cause, directly or indirectly, by intemperance or any pernicious habit (use of alcohol, narcotics, etc.)? Please specify.	

9. Names and addresses of other physicians who attended to the Deceased for his/her last illness and prior illness.

Treatment Date	Diagnosis	Treatment	Details of Clinic/Hospital/Doctor

10. Was a Coroner's inquest or post-mortem examination conducted on the body? If "Yes", please furnish certified copy of verdict or findings.	
TO BE COMPLETED IF THE CAUSE OF DEATH WAS DUE TO ACCIDENT	
11. Date and time of accident	Date: ☐☐ MM ☐☐ DD ☐☐☐☐ YYYY Time: ☐☐☐☐ am/pm
12. Place of accident	
13. Nature of accident	
14. Was the Deceased suspected to be under the influence of any alcohol or drugs?	
15. In your opinion / investigation, do you think that the death resulted from the accident?	
16. Please give any other information which, in your opinion may be relevant to the death claim due to illness or accident	

Declaration – To be Completed By The Attending Physician /Specialist

I, the undersigned, certify that I have examined and treated the deceased for his/her injuries/illness/disease described above and I have answered the above questions are true and to the best of my knowledge and belief.

Name: ______________________

Address: ______________________

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Signature and Practice Stamp
(with qualification)

Date: ☐☐ - ☐☐ - ☐☐☐☐
DD MM YYYY

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential"**

  Claims Department Level 21, Mercu 2, No. 3 Jalan Bangsar, KL Eco City, 59200 Kuala Lumpur.

- Please attach certified true copy of relevant test results or imaging reports available
- All expenses in procuring this medical report shall be borne by the claimant