



DOCTOR'S STATEMENT – INDIVIDUAL CLAIM FOR DEATH BENEFIT

(Filled by attending Physician)

To the esteemed attending physician,
We kindly request your assistance in completing this Medical Certificate truthfully, based on the data available and within your professional knowledge.

DETAILS OF THE INSURED

Patient's Name : _____ Gender: M/F Patient/Medical Record No. : _____
Date of Birth : _____ / _____ / _____ (DD/MM/YYYY) / Age ____ y.o. Patient's Address : _____
Type of Treatment : ☐ Inpatient ☐ Pre/Post Inpatient ☐ Accident $\geq$ / $\leq$ 48 hours prior to hospital admission
☐ Permanent Disability ☐ One Day Surgery ☐ Critical Illness

CAUSE OF DEATH INFORMATION

Date & Time of Death : _____ / _____ / _____ (DD/MM/YYYY), Time : _____
Place of Death : _____
If the patient passed away at home, please provide a detailed chronology

Circumstances Leading to Death ☐ Accident ☐ Illness/Medical Condition (please provide explanation) _____
Diagnosis : _____

IF DEATH DUE TO ILLNESS

Since when did the patient experience symptoms prior to the first consultation _____ / _____ / _____ (DD/MM/YYYY) / For how long _____
Physicians Previously Involved in Treatment : _____ Hospital : _____
Supporting Examination Results
(Laboratory, Radiology, MRI, CT Scan, Angiography, Pathology Anatomy, USG)

Type of Surgery (if performed) : ☐ No ☐ Yes, Please specify the surgical procedures undertaken _____

IF DEATH WAS RELATED TO AN ACCIDENT

Accident Chronology : _____

Was the accident related to or caused by any of the :
Alcohol ☐ No ☐ Yes, please explain _____
Narcotics/Other Drugs ☐ No ☐ Yes, please explain _____

PREVIOUS MEDICAL HISTORY

Does the patient suffer from or have a history of conditions related to Hypertension, Diabetes Mellitus, Heart Disease, Pulmonary Disease, Psychiatric Disorders, Congenital Conditions, Substance Abuse/Narcotics, HIV, or other illnesses? ☐ No ☐ Yes, Please explain _____
Diagnosis : _____ Since _____ / _____ / _____ (DD/MM/YYYY)
Attending Physician : _____ Hospital : _____
Was the cause of death related to any of the above-mentioned conditions? ☐ No ☐ Yes, please explain _____

With this statement, I hereby declare that I have read and answered all of the above questions completely and truthfully.

Name of Physician : _____

Address of Physician : _____

Telephone/Mobile Number : _____

Signature & Official Hospital Stamp