

**DEATH CLAIM
DOCTOR'S STATEMENT**

Policy No. <input type="text"/>	New NRIC No. <input type="text"/> - <input type="text"/> - <input type="text"/>
Policy No. <input type="text"/>	Old NRIC/Birth Certificate/ Passport No. <input type="text"/>
Policy No. <input type="text"/>	Name of Deceased _____
Policy No. <input type="text"/>	

The above name is insured with GREAT EASTERN LIFE ASSURANCE (MALAYSIA) 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	<input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
2. Height / Weight	_____ (cm) _____ (kg)
3. Are you the Deceased's regular / family doctor? If "YES", since what date?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> / <input type="text"/> / <input type="text"/> (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, pre-malignant condition, cancer 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? If "YES", (i) What were the symptoms presented? (ii) Date of symptoms started (iii) What was the diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (ii) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (iii) _____ _____
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6. Was the Deceased hospitalised? If "YES", please state the: (i) Name of hospital admitted (ii) Date of First admission Date of Last admission (iii) Name(s) of attending doctor(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (ii) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (iii) _____ _____
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7. Was other doctor referring the Deceased to you? If "YES", please state the name(s) and address(es) of the attending doctor(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
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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. What is the underlying cause of the illness as per diagnosis above?

10. (a) Was there any predisposing cause(s) of the Deceased's death in relation to his/her habits (use of alcohol, narcotics, etc), family history, occupation?

Yes No

If "YES", please provide details:

(b) Was there any predisposing cause(s) of the Deceased's death in relation to his/her previous illness?

Yes No

If "YES", please provide details:

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

SECTION II: This section is applicable to ACCIDENTAL DEATH 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.

Name: _____

Address: _____

Date: / / (dd/mm/yyyy)

Signature and Official Stamp