

2. (a) What other significant condition did the deceased suffered from?

Brief Description of Illness(es)	Date(s) Diagnosed (DD/MM/YY)	Name and Address of Attending Doctor

(b) Was there any predisposing cause of the deceased's death (e.g. alcohol, narcotics etc, family history or occupation)? YES / NO*

If "YES", please give full details including the date of commencement and source of information.

3.

Cause of Death	Approximate Interval Between Onset and Death			
	Years	Months	Days	Hours
(a) _____ due to (or as a consequence of)				
(b) _____ due to (or as a consequence of)				
(c) _____ due to (or as a consequence of)				

4. Did the deceased consult any other doctor(s) before consulting you? YES / NO*

If "YES", please give his/ her name and address.

5. Please provide us with any other additional information that will enable the Company to assess this claim.

_____ Date

_____ Signature & Official Stamp of Doctor