

**DEATH - STATEMENT OF MEDICAL EXAMINER**

**SECTION B**

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Deceased for the injuries / illnesses sustained

2. Expenses incurred to obtain this report will be borne by the Claimant / Next of Kins

**Contract No :** \_\_\_\_\_

1 Name of the Deceased in full \_\_\_\_\_

2 New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

3 Deceased's Address at time of death \_\_\_\_\_  
\_\_\_\_\_

4 Occupation at the time of death \_\_\_\_\_

5 Date of death \_\_\_\_\_ (dd/mm/yyyy) Time : \_\_\_\_\_ (am/pm)

6 Place of death \_\_\_\_\_

7 Cause of death \_\_\_\_\_

8 Any disease or condition **directly** leading to death ?  Yes  No

If yes, please give details:-

i. Disease or condition **directly** leading to death \_\_\_\_\_

ii. When was the disease or condition diagnosed? \_\_\_\_\_ (dd/mm/yyyy)

iii. By whom was the disease or condition diagnosed? Please give name and address of doctor  
\_\_\_\_\_

iv. Was the Deceased/family informed of the diagnosis?  Yes  No If yes, when? \_\_\_\_\_ (dd/mm/yyyy)

9 When did the Deceased **first** consult you? \_\_\_\_\_ (dd/mm/yyyy)

10 Diagnosis at the **first** consultation \_\_\_\_\_

11 What symptoms had Deceased been having prior to the **first** consultation with you? \_\_\_\_\_

12 In your opinion, how long do you feel the Deceased had the symptom? \_\_\_\_\_ (month)

13 Are you the Deceased's regular / family doctor ?  Yes  No

i. If yes, since when ? \_\_\_\_\_ (dd/mm/yyyy)

ii. If no, please give name and address of Deceased's regular doctor (if known)  
\_\_\_\_\_

14 Please briefly detail the Deceased's medical history

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Treatment given

15 Was the Deceased referred to you by another doctor?  Yes  No

If yes, please give name and address of the doctor \_\_\_\_\_  
\_\_\_\_\_

16 Did you attend to Deceased's last illness ?  Yes  No  
 If no, please give name and address of the attending doctor \_\_\_\_\_  
 \_\_\_\_\_

17 Was death due to  self-inflicted  homicide  accident

18 If death due to accident, please give details :-  
 i. Date of accident : \_\_\_\_\_ (dd/mm/yyyy) Time : \_\_\_\_\_ (am/pm)  
 ii. How did the accident happen? \_\_\_\_\_  
 iii. Was the Deceased suspected to be under the influence of any alcohol or drug?  Yes  No  
 a. If yes, was three any sample of urine or blood sent for further test?  Yes  No  
 iv. In your opinion / investigation, do you think that death resulted from the accident?  Yes  No

19 Was there any predisposing cause directly or indirectly to Deceased's death?  
 i. Habits use of tobacco, alcohol, narcotics  Yes  No  
 ii. Family History  Yes  No  
 iii. Occupation of Deceased  Yes  No  
 iv. HIV / AIDS  Yes  No  
 If 19(iv) is yes, was the illness transmitted via blood transfusion?  Yes  No

20 If the Deceased diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the **first** recording done:  

Date (dd/mm/yyyy)	Readings of Blood Pressure	Date (dd/mm/yyyy)	Result for Blood Gulcose (fasting)
i. _____	_____	i. _____	_____
ii. _____	_____	ii. _____	_____

21 Details of other attending doctors who had treated the Deceased in the last **two** years  
 \_\_\_\_\_  
 \_\_\_\_\_

22 Any further information which in your opinion will assist us in assessing the claim ?  
 \_\_\_\_\_  
 \_\_\_\_\_

**DECLARATION**

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : \_\_\_\_\_  
 Name of Doctor : \_\_\_\_\_  
 Qualification : \_\_\_\_\_  
 Telephone no : \_\_\_\_\_  
 Fax no: \_\_\_\_\_  
 Date : \_\_\_\_\_

Official Stamp of Doctor & Hospital/Clinic  
 \_\_\_\_\_  
 \_\_\_\_\_