

**DEATH CLAIM  
DOCTOR'S STATEMENT**

Policy No. <input style="width:100%;" type="text"/>	New NRIC No. <input style="width:100%;" type="text"/>	- <input style="width:100%;" type="text"/>
Policy No. <input style="width:100%;" type="text"/>	Old NRIC/Birth Certificate/ Passport No. <input style="width:100%;" type="text"/>	
Policy No. <input style="width:100%;" type="text"/>	Name of Deceased _____	
Policy No. <input style="width:100%;" 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 style="width:100%;" 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 style="width:100%;" 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 style="width:100%;" 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 style="width:100%;" type="text"/> (dd/mm/yyyy) <input style="width:100%;" 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