eTiQa Takaful

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 borned 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 Decaesed 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 : _____ Official Stamp of Doctor & Hospital/Clinic

Name of Doctor : _____

Qualification : _____

Telephone no : _____

Fax no: _____

Date : _____ _____

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