STATEMENT OF MEDICAL EXAMINER – DEATH CLAIM

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 s/ illness sustain.
2. Expenses incurred to obtain this report will be borne by the Claimant / Next of Kin.

Contract no: ……

Name of deceased in full: ……..

NRIC no. : …… Sex: ☐ Male ☐ Female Age: ……..

Date of Birth: …… Occupation at time: ……...

1. Deceased's Address at Time of Death ……...

2. Date and Time of Death: …… 3. Place of Death: ……

4. Are you the patient's regular doctor? ☐ Yes ☐ No

5. Since when have you known the deceased?……..

6. i) Date the patient first consulted you (dd/mm/yyyy) :……..

ii) What was the diagnosis at the first consultation:……

iii) According to the deceased, how long do you feel the deceases had the symptom:……

iv) In your opinion, how long do you feel the deceased has the symptom;……..

7. i) Were you consulted by the deceased during his/her last illness? ☐ Yes ☐ No

ii) If not, please give the name and address of the attending doctor: ……..

8. If deceased was hospitalized, please state:

Admission Date: …… Discharge Date: …… Diagnosis: …….. Place: ……..

…… …… …….. ……..

…… …… …….. ……..

9. a) What was the immediate cause of death? Give disease, injury or complication which caused death not the code of dying such as heart failure, asphyxia, asthenia, etc:……

b) When, where and by whom was the illness first diagnosed? Date: …… Place: …… By Whom: ……

c) Was Deceased/ family informed of the diagnosis? ☐ Yes ☐ No

10. a) If the primary cause of death differs from the immediate cause, please state the primary cause

……

b) When and where it was first diagnosed? Date: …… Place: ……..

c) Was Deceased / family informed of the diagnosis? ☐ Yes ☐ No

d) Was the Deceased referred to you by other doctor? ☐ Yes ☐ No

Please state reason: …….. Please give name and address of the doctor: ……

11. Give details of any follow-up(s), or referral by / to other doctor(s), if any

Name & Address of Doctors / Hospital	Date of Attendance	Illness or condition consulted
……	……	……
……	……	……
……	……	……

12. Was death due to ☐ self-inflicted ☐ homicide ☐ accident ☐ suicide

i.Please give details ……

……

ii. If due to suicide please advise was there any history of mental illness / disorder that could lead to suicide? ☐ Yes ☐ No

iii. Please provide details of previous consultation(s) with psychiatrist due to his / her mental illness (if any):

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

13. 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 there any sample of urine or blood sent for further test? ☐ Yes ☐ No

iv. In your opinion / investigation, do you think that the death resulted from the accident? ☐ Yes ☐ No

14. Was there any predisposing cause directly or indirectly to Deceased's death?

i. Habit use of tobacco, alcohol, narcotics ☐ Yes ☐ No

ii. Family History ☐ Yes ☐ No

iii. Occupation of Deceased ☐ Yes ☐ No

iv. HIV / AIDS ☐ Yes ☐ No

If 13 (iv) is yes, was the illness transmitted via blood transfusion? ☐ Yes ☐ No

15. Please state below from past records or from your personal knowledge details of all illnesses, accidents, treatments and/or surgical procedures performed for the diseases that deceased had suffered from in this hospital or any other hospitals.

Date of Onset / Diagnosed	Symptoms	Disease / Diagnosis	Treatment / Management	Name of Hospital / Clinis

16. Was an inquest or post-mortem examination held on the body? ☐ Yes ☐ No

If yes, please furnish certified copy of verdict or findings

If so, state which, by whom and the results ……

17. 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 Glucose (fasting)
i.	……	…… …	……	……
ii.	……	…… …	……	……
iii.	……	…… …	……	……

18. Details of other attending doctors who had treated the Deceased in the last **two** years

……

19. Any further information which in your opinion will assist us in assessing the claim? ……

……

20. **To detailed medical history / medical card of the Deceased.**

DECLARATION

I, the attending physician do solemnly and sincerely declare that the foregoing answer and any additional information given by me at the bottom of this 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 : ……

Name and Address of Clinic / Hospital: ……

……

Official Stamp of Doctor : Hospital / Clinic Official Stamp

…… ……

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
(Licensed under Islamic Financial Services Act 2013 and regulated by Bank Negara Malaysia)
Dataran Maybank, No. 1, Jalan Maarof, 59000 Kuala Lumpur
T +603 2297 3888 F +603 2297 3800 E info@etiqa.com.my
www.etiqa.com.my
Etiqa Oneline 1300 13 8888
Ahli Kumpulan Maybank