

Tel: 67371221 Website: www.manulife.com.sg

ATTENDING PHYSICIAN'S STATEMENT DEATH CLAIM

| Nam | e of Deceased | NRIC Number | NRIC Number | | | | |
|-------|---|---|---------------------------------------|--|--|--|--|
| | | | | | | | |
| Polic | ey Number | Claim Number (F | For internal use) | | | | |
| | th claim has been submitted. To enable us to letion of this form. | assess the claim, we would be grateful fo | r your co-operation in the | | | | |
| A. | GENERAL INFORMATION | | | | | | |
| 1. | Are you the deceased's usual medical doctor? | Yes N | lo | | | | |
| | If yes, over what period do your records extend Start date / / yyyy | o? End date // | y | | | | |
| 2. | When did the deceased first consult you for this condition? / / yyyy | | | | | | |
| 3. | Please state symptoms presented and date sym | Please state symptoms presented and date symptoms first appeared. | | | | | |
| | Symptoms Presented at First Consulta | tion Date Symptoms First Star | rted (DD/MM/YYYY) | | | | |
| | | 1 | | | | | |
| | What / who is the source of this information? | | | | | | |
| 4. | In your opinion, what were the likely durations of the deceased's symptoms? Please provide reasons. | | | | | | |
| | | | | | | | |
| 5. | Did the deceased consult any other doctors for the lf yes, please provide details below. | ese symptoms <u>before</u> he/she consulted you? | Yes | | | | |
| | Name of Doctor | Name of Clinic / Hospital a | Name of Clinic / Hospital and Address | | | | |
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B. DETAILS OF DEATH

| ô. | (a) | What was the diagnosis? Please describe the full details of the diagnosis |
|----|-----|--|
| | | |
| | (b) | Date of diagnosis// dd _mmyyyy |
| | (c) | Please provide treatment rendered and date of treatment rendered. |
| | | |
| | (d) | What was the exact information conveyed to the deceased? |
| | | |
| | (e) | What was the duration between the onset of the condition/illness and death? |
| | | |
| | (f) | Please provide details of any other significant illnesses that the deceased suffered from and the date of diagnosis? Was the cause of death due to any of the other significant illnesses listed? |
| | | |
| | (g) | Was there any predisposing cause of the deceased's death in his/her habits (use of alcohol, narcotics, etc), family history, occupation or previous sickness? If "YES, please give full details including the date of commencement and source of information. |
| | | |



C. ADDITIONAL INFORMATION

| Please provide us with any other additional information that will enable the Company to assess this claim. | | | | | |
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| Signatu | re of Doctor | | Date | | |
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| | | | | | |
| | | | Addre | ess & Official Star | np |
| | | | | | |
| Name ar | nd Qualification (printed) | | | | |
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