FWD insurance

Celebrate living
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Death claim: doctor's statement

Deceased's particulars

Name of deceased

NRIC/FIN/Passport

Gender ☐ Male ☐ Female

Deceased's medical records

Date of deceased 's first consultation with you
(dd/mm/yyyy)

What were the patient's symptoms or complaints presented during first consultation?

Has the patient had similar or related conditions/symptoms previously?

Date of subsequent consultation

Date symptom first started
(dd/mm/yyyy)

In your opinion, what were the likely durations of the deceased's symptoms? Please provide reasons

Did the deceased consult any other doctors for these symptoms before he/she consulted you? ☐ Yes ☐ No

If "yes", name of doctor & clinic name & address

Name of doctor and clinic name

Address of doctor

Date of the first diagnosis
(dd/mm/yyyy)

Date of consultation & reason

Diagnosis

What was the duration between the onset of condition/illness and death

Was the deceased informed of the diagnosis?
If "yes", when was the deceased first told? (dd/mm/yyyy)

What was the exact information conveyed to the deceased?

What was the treatment administered and the period of treatment?

Was the patient recommended to receive medical advice, tests, treatment, diagnosis or prescribed drugs within the last 12 months? If "yes", please specify

Was the condition or treatment related directly or indirectly to:	Yes	No
Congenital abnormalities or developmental disorders	☐	☐
Cosmetic/plastic surgery	☐	☐
Dental/gum treatment	☐	☐
Psychological, mental or emotional disorders	☐	☐

	Yes	No
Sexually transmitted disease, AIDS or HIV related infection	☐	☐
Alcohol, drug abuse or use of unprescribed drug where such drugs are required by law to be prescribed by a registered doctor	☐	☐
Pregnancy, childbirth, infertility, impotence, contraception, abortion	☐	☐
Self-inflicted injuries or injuries resulting from attempted suicide	☐	☐
Treatment for obesity	☐	☐

Details of surgical procedures and treatment

Type of operation	Date performed	Name of surgeon	Name of anesthetist

If patient was referred to another doctor for follow up, please furnish name and clinic of doctor

Did the deceased suffer from any other illness?
If "yes", please provide detail of illness/date diagnosed (dd/mm/yyyy)

Please provide name and address of the deceased's regular doctor

Details of death

Immediate cause of death

How long has the illness been existing prior to death?

Doctor's certification

I hereby certify that I have personally examined and treated the patient for the above condition and the answers given represent my medical opinion of his/her condition.

Signature of doctor

Name and designation of doctor

Name of clinic/hospital and stamp

Date (dd/mm/yyyy)

Name of clinic/hospital