AVIVA LTD
4 Shenton Way #01-01, SGX Centre 2, Singapore 068807
Telephone: 6827 7988 Fax: 6827 7900 Company Reg. No. 196900499K

DEATH CLAIM – PHYSICIAN'S STATEMENT

To be completed by Attending Physician. All medical report fees incurred shall be borne by the claimant.

1) Name of Deceased:	I.C./Passport/ B.C. No.	Date of Birth:
2) Name of Deceased's Company:	Occupation:	
3) Date of Death:	4) Place of Death:	
5) a) Please state over what period do your records extend? From ________________________ (dd/mm/yy) to _______________________ (dd/mm/yy) b) Are you the Deceased 's regular attending doctor? ☐ Yes ☐ No If "NO", please advise name of the regular attending doctor and the address of clinic / hospital.		
6) What was the Immediate Cause of Death?	7) How long has the illness been existing prior to Death?	
8) Did Deceased have any symptoms prior to Death? ☐ Yes ☐ No If "YES", Date symptoms first appeared: Details of Symptoms Presented:	9 a) Date the Deceased first consulted you for this condition: b) Date the Deceased last consulted you for this condition: c) Number of consultations during above period:	
10) Did Deceased have had any similar or related symptoms prior consulting you? ☐ Yes ☐ No If "YES", please specify:	11 a) Name of the doctor and address of the clinic / hospital the Deceased **First** consulted for related or similar symptoms? b) Date Deceased **First** consulted for the similar or related symptoms? (dd/mm/yy) : c) Source of Information:	
12) Treatment prescribed:	13) Date of Treatment prescribed:	
14a) What was the diagnosis leading to the cause of Death first diagnosed? Diagnosis: b) When was the diagnosis leading to the cause of death first diagnosed? Date of Diagnosis:	15) Was the Deceased informed of the diagnosis? ☐Yes ☐ No If "YES", Date the Deceased was First informed: If 'NO', why not?	

Signature of Physician…………………………………

Cont'd

16a) Was the Deceased referred to your clinic / hospital? ☐ Yes ☐ No

If "YES", please provide the name of the doctor and address of the clinic / hospital who referred the Deceased:

If "NO", please provide us the details on how you knew of the information. Who is the source of information?

17) From what other significant health conditions was the Deceased suffering from?

Illness	Date of Diagnosis (dd/mm/yy)	Type of Treatment	Name & Address of Attending Doctor

18) Was the Death in any way partly attributed to the Deceased's habits (i.e. use of alcohol, narcotics etc), family history, occupation, or previous diseases?
☐ Yes ☐ No

If "YES", please give details including the date of diagnosis and source of information.

19) Please provide us with any other additional information that will enable Aviva to assess the claim.

20) Doctor(s) whom you have not mentioned above but the Deceased had previously consulted for any or all of the above conditions, or is in your record:

Name of Doctor	Approximate Date	Name and Address of Clinic / Hospital
(a)		
(b)		
(c)		

Cause of Death :	Approximate Interval Between onset and death			
	Years	Months	Days	Hours
(a) …………………………………………………	……………………	……………………	……………………	…………
(b) …………………………………………………	……………………	……………………	……………………	…………
(c) …………………………………………………	……………………	……………………	……………………	…………

Please attach copies of any specialist or hospital reports, investigation results, post mortem, autopsy report, etc, together with this report to assist and support this claim.

Thank you for your assistance.

Name of Doctor : ………………………………………………………………

Clinic's Address & Stamp: ……………………………………

Signature of Doctor: ……………………………………………………………..

……………………………………………………………………..

Date : ……………………………………………………………………………..

………..………………………………………………………...