Gibraltar BSN

DEATH CLAIM
ATTENDING PHYSICIAN'S MEDICAL REPORT

Policy No.:

Name of Life Assured (Deceased): **Age :**

NRIC No. / Birth Cert / Passport No.: **Gender :** ☐ **Male** ☐ **Female**

INFORMATION ON DEATH AND MEDICAL HISTORY

1. Are you the deceased's usual medical physician?	☐ **Yes** ☐ **No**
a) Date of FIRST consultation	**a)** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
b) Please state the reason for the FIRST consultation.	**b)**
c) What were the symptoms complained of?	**c)**
d) How long had the Deceased been experiencing these symptoms prior to consulting you?	**d)**
2. Did you attend to the Deceased during his/her last illness?	☐ **Yes** ☐ **No**
a) If "Yes", what was the disease / medical condition?	**a)**
b) Date that Deceased was informed of the disease	**b)** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
c) If "No", on what date did you last attend to the deceased? Please state the medical condition	**c)** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
3. Was the Deceased referred to you by any other doctor?	☐ **Yes** ☐ **No**
a) If "Yes", please state the name, address & contact no. of the doctor who referred the Deceased to you	**a)**
b) Please attach a copy of referral letter	**b)**
4. Please state the Cause of Death	
5. What were the underlying cause leading to the death?	
6. What were the other contributing causes of death? Please give as near as you can on the duration of each cause.	
7. What were the other significant disease the Deceased had suffered and for how long?	
8. Was the cause, directly or indirectly, by intemperance or any pernicious habit (use of alcohol, narcotics, etc.)? Please specify.	

9. Please provide details of diagnosis, treating doctors / hospitals who had ever attended to the Deceased.

Date	Nature of Complaints / Diagnosis	Name of Doctor / Hospital

Gibraltar BSN Life Berhad [277714-A]
Level 21, Mercu 2, No. 3 Jalan Bangsar, KL Eco City, 59200 Kuala Lumpur
Customer Careline: 1-300 22 6262 General Line: 03-2298 2000 Fax: 03-2298 2222
Email: customerservice@gibraltarbsn.com www.GibraltarBSN.com

CLM/40/DC Part II/072018 v2

TO BE COMPLETED IF THE CAUSE OF DEATH WAS DUE TO ACCIDENT	
10. Date and Time of accident	**Date:** ☐☐ **MM** ☐☐ **DD** ☐☐☐☐ **YYYY** **Time:** ☐☐☐☐ **am/pm**
11. Place of accident	
12. Nature of accident	
13. Was the Deceased suspected to be under the influence of any alcohol or drugs?	
14. In your opinion / investigation, do you think that the death resulted from the accident?	
15. Any further information which, in your opinion, will assist us in assessing the claim?	

Declaration – To be Completed By The Attending Physician /Specialist

I, the undersigned, certify that I have examined and treated the deceased for his/her injuries/illness/disease described above and I have answered the above questions are true and to the best of my knowledge and belief.

Name: _____

Address: _____

_____

_____

Signature and Practice Stamp
(with qualification)

Date: ☐☐ - ☐☐ - ☐☐☐☐
DD **MM** **YYYY**

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential"**

  Claims Department Level 21, Mercu 2, No. 3 Jalan Bangsar, KL Eco City, 59200 Kuala Lumpur.

- Please attach certified true copy of relevant test results or imaging reports available
- All expenses in procuring this medical report shall be borne by the claimant