



## Report on Medical attendant

1. Name of doctor/medical attendant that completed the report \_\_\_\_\_

2. Name of deceased/insured \_\_\_\_\_

3. ID number/date of birth of the deceased/insured\ \_\_\_\_\_

4. Date of death YYYY/MM/DD \_\_\_\_\_

5. Place of death (town/region) \_\_\_\_\_

6. Age at death \_\_\_\_\_

7. Have you treated the deceased on a regular basis before his/her death?

YES  NO

8. If you answered NO to question (7) please provide detail on the deceased's usual medical attendant: \_\_\_\_\_

9. Where did the death occur?

HOSPITAL/CLINIC  HOME  OTHER

10. What was the immediate cause of death? \_\_\_\_\_

11. When did the deceased first experience or become aware of symptoms associated with the immediate cause of death as mentioned in (10)?

YYYY/MM/DD \_\_\_\_\_ UNKNOWN

12. When was the diagnosis of the condition that caused the death as mentioned in (10) first made?

YYYY/MM/DD \_\_\_\_\_ UNKNOWN

13. In your opinion, for what period (BEFORE the death) was the immediate cause of death as mentioned in (10) present/identifiable?

0-30 days  31-60 days  >60 days

14. Did any other medical condition contribute in any way to the immediate cause of death as mentioned in (10)?

YES  NO

15. If you answered YES to question (14) please provide the diagnosis of the condition(s) that contributed to the immediate cause of death: \_\_\_\_\_

16. In your opinion, for what period (BEFORE the death) was the contributory cause of death as mentioned in (15) present/identifiable?

0-30 days  31-60 days  >60 days  No contributory cause present

17. In your opinion, was the death HIV related in any way?

YES  NO  UNKNOWN

18. Was the deceased ever tested for HIV?

YES  NO  UNKNOWN

19. What was the result of the HIV test if the deceased was tested?

POSITIVE  NEGATIVE  UNKNOWN  NEVER TESTED

20. Please state the date of the HIV test: \_\_\_\_\_

21. Was the death caused by Tuberculosis (pulmonary or extra-pulmonary)?

YES  NO  UNKNOWN

22. Was the death caused by pneumonia?

YES  NO  UNKNOWN

23. Was the death caused by an accident of any kind?

YES  NO

24. If the death was indeed caused by an accident, how long prior to the death did the accident occur?

0-30 days  31-60 days  >60 days  NOT APPLICABLE

25. Was the death a result of participation in any dangerous recreational activity/sport?

YES  NO

26. Was the death caused by any action on the behalf of the deceased himself/herself (i.e. ingestion of lethal substance, drug abuse, suicide by any method)?

YES  NO  NOT APPLICABLE

27. If the insured was hospitalized in the 3 months prior to his/her death, please state date of admission and date of discharge:

From YYYY/MM/DD \_\_\_\_\_ to YYYY/MM/DD \_\_\_\_\_ NOT APPLICABLE

28. Was a post-mortem done?

YES  NO  *If yes submit post-mortem reprot with this report*

29. Kindly attach ALL relevant documentation regarding the medical condition/cause of death.

DATED at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

SIGNATURE \_\_\_\_\_ ADDRESS \_\_\_\_\_

PRINT NAME \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

