中国人寿保险(新加坡)有限公司
China Life Insurance (Singapore) Pte. Ltd.

ATTENDING PHYSICIAN STATEMENT (DEATH CLAIM)

Important Notes

1. This form is to be completed by the life insured's (Patient's) doctor.
2. Please ensure that the form is duly completed. If any of the questions are not applicable, please state 'N/A.'
3. Any expense that is incurred in obtaining any of the documents required, including but not limited to the Doctor's Statement or medical evidence, for claim filing shall be borne by the claimant.
4. All documents submitted must be in English. Any document which is in a foreign language must be translated to English by a certified translator.
5. We reserve our rights to request for additional information or documents, if needed.
6. If you have any questions while completing this form, please contact our Customer Care Hotline at (65) 6727 4800.

1. Patient's Information

Full name of Patient (Life Insured)	NRIC No./ Passport No. (for foreigners only)

2. Medical History

(i) Are you the Patient's usual doctor?

☐ Yes ☐ No

(ii) Over what period do your records extend?

Start date (dd/mm/yyyy _____/_____/_____

End date (dd/mm/yyyy _____/_____/_____

(iii) Did you attend to the Patient's last illness?

☐ Yes ☐ No

If yes, please provide the details below

Date of Consultation (dd/mm/yyyy)	Symptoms Presented	Duration of Symptom	Diagnosis	Date of First Diagnosis (dd/mm/yyyy)	Medical Treatment Provided

(iv) Was the Patient referred to you by another doctor?

☐ Yes ☐ No

If "Yes", please provide details

Name of Referring Doctor	Name and address of clinic/ hospital	Date Patient consulted referring doctor (dd/mm/yyyy)	Reason(s) for the Referral

(v) Did you refer the Patient to another doctor for further evaluation?

☐ Yes ☐ No

If "Yes", please provide details

Name of Doctor whom the Patient was referred	Name and address of clinic/ hospital	Date Patient consulted doctor (dd/mm/yyyy)	Reason(s) for the Referral

3. Cause of Death

(i) What is the cause of death?

(ii) What is the interval between onset and death?

(iii) Please state the name and address of the doctor who treated the deceased for this condition.

(iv) Please provide details of any significant medical conditions that the deceased suffered from.

Medical Condition	Date of Diagnosis (dd/mm/yyyy)	Name and address of doctor consulted

(v) Was the deceased's illness caused by any other underlying medical condition(s) or disorder(s)?

☐ Yes ☐ No

If "Yes", please provide details

(vi) Was the deceased's condition caused by an accident?

☐ Yes ☐ No

If "Yes", state:

(a) Date of Accident (dd/mm/yyyy): _____/_____/_____

(b) Time of Accident :_____(AM/PM)

(c) Place of Accident : _____

(d) Please provide details of the accident

(vii) Was the deceased's condition in any way related or due to :

a.	Attempted suicide or self-inflicted injuries?	☐ Yes ☐ No
b.	AIDS, AIDS-related complex or infection by HIV?	☐ Yes ☐ No
c.	Congenital or hereditary diseases or disorder?	☐ Yes ☐ No
d.	Mental and personality disorders (excluding Dementia and Alzheimer's disease)?	☐ Yes ☐ No
e.	Improper use of alcohol, alcohol abuse or alcohol dependence?	☐ Yes ☐ No
f.	If you answered 'Yes' to any of the above Question 3(vii) (a) to (e), please provide details:	

_____ Name and Signature of Doctor	_____ Date (dd/mm/yyyy)
_____ Address and official stamp of the Doctor	_____ Qualification