* S U P D O C *

AVIVA

DEATH CLAIM – DOCTOR'S STATEMENT

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

1) Name of Deceased	ID/FIN/Passport/BC No.
2) Name of Deceased's Company	3) Occupation
4) Place of Death	5) Date of Death (ddmmyyyy)
6) What is the immediate Cause of Death?	7) How long has the illness been existing prior to Death?

8) Did the Deceased have any symptoms prior to Death? ❒ Yes ❒ No

If "Yes", please state symptoms presented and date symptoms first appeared.

a) Date symptom first started (ddmmyyyy)	b) Describe the symptom 1st presented
c) When did Deceased first consult you for this condition? (ddmmyyyy)	d) Date and Nature of Treatment rendered

e) What is the source of this information? Please specify the name of the person and relationship to the Deceased.

9) When was the diagnosis leading to the cause of Death first diagnosis? (ddmmyyyy)	10) Was the Deceased informed of the diagnosis? ❒ Yes ❒ No If "Yes", when was the Deceased first told? (ddmmyyyy)

11) Did the Deceased suffer from any other illness? If "Yes", please state: ❒ Yes ❒ No

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

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12) Was there any predisposing cause of the Deceased's death in his/her habits (use of alochol, narcotics, etc.), family history, occupation or previous sickness? If "Yes", please provide details including the date of commencement and souce of information.	❒ Yes ❒ No
13) Did the Deceased consult any other doctor(s) before consulting you? If "Yes", please provide details including the name and address of doctor and reason for consultation.	❒ Yes ❒ No
14) Please provide us with any other additional information that will enable the Company to assess this claim.	

Declaration	
I hereby declare that the above answers are true to the best of my knowledge and belief.	
Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (dd / mm/ yyyy)	

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