Sun Life Malaysia Assurance Berhad* (197499-U)
Sun Life Malaysia Takaful Berhad* (689263-M)
Level 11, 338 Jalan Tuanku Abdul Rahman, 50100 Kuala Lumpur.
Telephone : (603) 2612 3600 Fascimile : (603) 2698 7035
Customer Careline : 1300-88-5055 www.sunlifemalaysia.com

Policy / Contract / Certificate No. : _____

Note : To be completed by the deceased's last attending doctor at the claimant's expense.

MEDICAL REPORT ON DEATH CLAIM

SECTION A : DECEASED'S PARTICULARS

Name of Deceased

NRIC number (new) – –

Other identification number (if any)

Gender ☐ Male ☐ Female

Date of Birth D D – M M – Y Y Y Y

Nationality

Height : _____ **(cm)** **Weight :** _____ **(kg)** **Date Measured :** D D – M M – Y Y Y Y

SECTION B : DECEASED'S MEDICAL RECORD

1. **Are you the deceased's regular / family doctor?** ☐ **Yes** ☐ **No**
2. **When did the deceased <u>first</u> consulted you?** D D – M M – Y Y Y Y
3. **Diagnosis :** _____
4. **Was the deceased referred to you by any other doctor?** ☐ **Yes** ☐ **No**
   a) **Referral Date** D D – M M – Y Y Y Y **b) Referral Doctor :** _____
   c) **Clinic / Hospital :** _____
   d) **Referral Reason :** _____
5. **Death Date** D D – M M – Y Y Y Y **6. Time of Death** : **(am / pm)**
7. **Place of Death :** _____
8. **Cause of Death :** _____
9. **Underlying Cause :** _____

If the death was due to an ACCIDENT, please complete the following :

10. **Accident Date** D D – M M – Y Y Y Y **11. Accident Time** : **(am / pm)**
12. **Place of Accident :** _____
13. **Nature of Accident :** _____
14. **Injuries Sustained :** _____
15. **Circumstances of the Accident :**

_____

_____

16. **Was Post Mortem / Autopsy carried out?** ☐ **Yes** ☐ **No** **If yes, please provide us a certified copy of the autopsy report.*
17. **Was the deceased suspected to be under the influence of any drugs or alcohol?** ☐ **Yes** ☐ **No**
    If yes, please give details. _____
18. **In your opinion / investigation, do you think that the death was resulted from the accident?** ☐ **Yes** ☐ **No**
    Please elaborate. _____
19. **Did you attend to the deceased during his/her last illness?** ☐ **Yes** ☐ **No**
20. **What were the symptoms presented? Symptoms :** _____
21. **Date the symptoms started** D D – M M – Y Y Y Y
22. **Diagnosis :** _____
23. **When was the disease FIRST diagnosed?** D D – M M – Y Y Y Y
24. **By whom was the disease / condition first diagnosed? Doctor's Name :** _____
    Clinic / Hospital : _____
25. **In your opinion, how long did the deceased suffer from this disease and was he/she under treatment / medication?**

_____

_____

Version : *06*/**2023**

*A joint venture between Sun Life Assurance Company of Canada and Renggis Ventures Sdn. Bhd.

26. Was there any predisposing cause(s) of the deceased's death in relation to his/her previous illness? ☐ **Yes** ☐ **No**

If yes, please give details.

_____

27. Was the cause of death relating to any of the following? If yes, please tick '√'

☐ **AIDS / HIV positive** ☐ **Congenital condition**

☐ **Self-inflicted** ☐ **Alcohol / drug abuse**

☐ **Suicide**

28. Was the deceased previously treated at your clinic / hospital? ☐ **Yes** ☐ **No**

Date	Symptoms	Diagnosis	Treatment

29. Did the deceased have any history of hospitalization for the past 2 years? ☐ **Yes** ☐ **No**

Admission Date	Diagnosis	Treating Doctor & Hospital

30. Have the deceased ever been treated or diagnosed with any of the following : **Treating Clinic / Hospital**

a) Hypertension ☐ **Yes** ☐ **No** **Since :** D D – M M – Y Y Y Y _____

b) Diabetes Mellitus ☐ **Yes** ☐ **No** **Since :** D D – M M – Y Y Y Y _____

c) Dyslipidaemia ☐ **Yes** ☐ **No** **Since :** D D – M M – Y Y Y Y _____

31. Did the deceased have any other medical condition or past medical history? ☐ **Yes** ☐ **No**

Diagnosis	Onset Date	Treating Doctor	Clinic / Hospital

32. Any other information that in your opinion may be relevant?

_____

_____

SECTION C : DECLARATION

I hereby certify that :

☐ I am the above named patient's attending doctor and I have personally examined and treated him/her for the illness/injuries sustained; **OR**

☐ I have personally perused the above named patient's medical record;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused and that no material fact has been withheld from the Company.

Date :

_____ D D – M M – Y Y Y Y

Doctor's Signature

Official Stamp

Doctor's Name : _____

Contact No. : _____

Clinic / Hospital : _____