CEYLINCO LIFE®
A Relationship For Life™
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DEATH CLAIM MEDICAL CERTIFICATE

Policy No. ....

1. Name in full of deceased Life Assured

2. Address

3. Occupation

4. Place, date and time of death

5. (a) What was the primary cause of death? (a) ....
   (b) How long was he suffering from that condition? (b) ....
   (c) What was the secondary cause of death? (c) ....
   (d) How long was he suffering from that condition? (d) ....
   (e) Did the deceased suffer from any other associated disease or conditions? (e) ....
   (Please give full particulars, including dates)

6. (a) Were you his usual medical attendant? Yes / No (a) ....
   (b) If "Yes" for how long? If "not" please state the name and address of such attendant (b) ....
   (c) Did you ever refer the deceased to a Consultant or to a Hospital for examination or treatment? (c) ....

7. (a) When did you first attend on him for the disease of which he died? (a) ....
   (b) How long were you in attendance during the last illness? (b) ....

8. Were any other doctors consulted during the last illness? If so, please state their names and addresses.

9. Have you attended on him on any other occasion? If so, Please state:
   (a) For what complaint (a) ....
   (b) Duration of each attendance (b) ....
   (c) Duration of each illness (c) ....

10. Give the history of any previous illness from which you have heard that he suffered, with the dates and names of the doctors who attended on him.

11. What was his apparent age?

12. (a) Was a post – mortem examination done? (a) ....
    (b) If "Yes", what was the cause of death determined? (b) ....
    (c) Was a Coroner's inquest held? (c) ....

13. How did you satisfy yourself regarding his identity?

I declare that the answers, I have given above are to the best of my knowledge, information and belief true, full and accurate.

Name ....

Signature..

Professional Qualifications

Registration No.

(Practice Stamp)

Address:

Date: