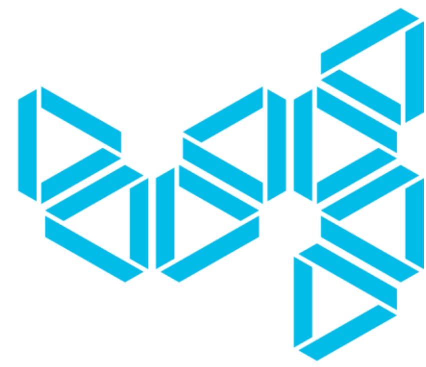

Certificate of Medical Attendant (in support of Death claim)

To be completed by the Medical Attendant (Treating Specialist)

Dear Doctor

This medical information requested in this report is in support of a policy benefit payable for the life insured. Your
expertise and advice will provide a vital link in the process of assessing the claim.

As this report is in support of a claim application, any cost in connection with this report will be for the account of
the life insured in terms of the policy, unless otherwise specified by Rand Mutual Life and confirmed in writing.

We thank you for your co-operation.

Section A: Medical Practitioner details

Full names and surname____

Address: ____

____

____

E-mail address:____

Cell phone number: ____

Business telephone: number:____

Practice number:____

HPCSA registration number:____

Qualification:____

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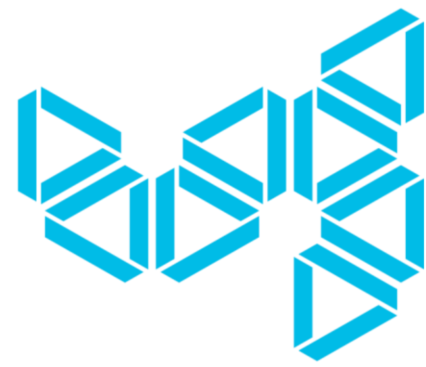

Section B: Life insured details

Policy number:____

Full names:____

Surname:____

ID number:____

Name of hospital/clinic:____

Hospital/Clinic file number:____

Section C: Medical references

Please give the details of any practitioners, specialists or hospitals to which the life insured has been referred. Please include copies of all available specialist reports and any investigations performed.

Name of Doctor	Contact Details of Doctor	Name of Facility (e.g. Hospital name)	Consultation Date	Treatment Details	Date of last visit to doctor

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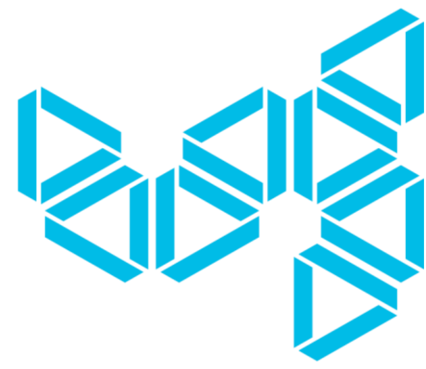

Section D: Medical history

Please give a full medical history, including the following:

Date of your first consultation with the life insured:_______________________________________

Date of your first consultation with regard to the medical condition which contributed to the death

____

Date of your last consultation with the life insured:____

Was the life insured on any chronic medication? Yes_____ No_______

If Yes, for what condition?____

Consultation Date	**Clinical presentation/ symptoms**	**Diagnosis**	**Treatment prescribed**	**Specialist referral or for further investigation**	**Compliance with treatment**

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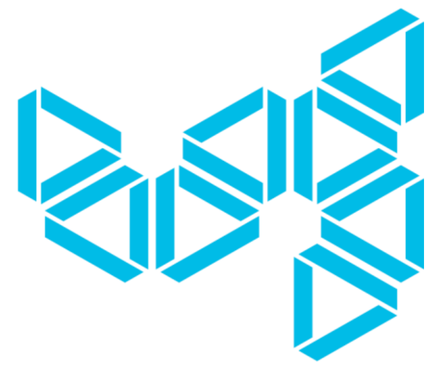

Has the Insured ever been tested for HIV antibodies? YES_____NO_____ Date:_________

Result_______________________________________(PLEASE ATTACH RESULTS)

Did the insured use tobacco in any form? YES____NO___

If so, how much_______

Did the insured consume alcohol on a weekly basis? YES____NO______

If yes, how many units per week? _________

Did you ever advise the insured to reduce their alcohol consumption? YES_____NO___

Section E: Cause of Death

Was an inquest or post mortem inquiry held? YES_____NO_____

What is the immediate cause of death? ____

Date of commencement of illness: ____

Date the insured first became aware of the symptoms: ________________________________

Was the Insured suffering from this condition when you were first consulted? YES_____NO___

State fully if any of the following contributed or predisposed to the cause of death:_________________

____

Previous Illness/injury: ____

____

Declaration by Medical Practitioner

I hereby declare that I have personally examined and attended to the life insured and that the contents of this report are true and correct.

Full names and surname____

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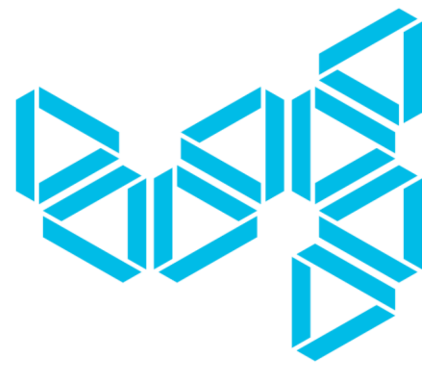

Doctor's signature____

Date and Stamp ____

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