

MEDICAL PRACTITIONER'S REPORT FORM

This form is to be filled in by the usual Family Doctor only. Please note the following requirements:

- The Family Doctor should have known/treated the patient for two years or longer.
- Please note that Esurity holds no responsibility for payment of any expenses for the completion of this form, that responsibility belongs solely to the claimant.

Policyholder's information

Policyholder: _____

Policy Number: _____

Reference Number: _____

Date of birth/ID Number:

Y	Y	M	M	D	D										
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Patient's information

Full names: _____

Date of birth/ID Number

Y	Y	M	M	D	D										
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Hospitalized at: _____

Date admitted

D	D	M	M	Y	Y	Y	Y
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Date discharged

D	D	M	M	Y	Y	Y	Y
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Doctor's information

Were you the deceased regular medical Doctor?

Yes	No
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If no, please detail the deceased's regular Doctor's information below:

How long have you been treating the deceased? _____

Reason for deceased's hospitalization _____

How long was the deceased treated for this condition _____

Was the deceased's hospitalization due to any of the following (please tick)

Childbirth, pregnancy or hysterectomy?

Illegally administered drug use

Alcohol abuse/poisoning

Suicide or self-inflicted injury

Congenital or childhood conditions

Mental illness or disorder

High risk activity (war, military, police)

If death was due to an accident, please list date

D	D	M	M	Y	Y	Y	Y
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Details of accident

Injuries sustained

Please detail any information not already mention but might be important to the processing of this claim

I, _____, hereby certify that all the information stated above and within this document is correct and complete. I know of no other conditions/injuries other than the ones mentioned.

Signature

Date signed