MEDICAL REPORT

TRUSTCO life
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UNDERWRITTEN BY TRUSTCO LIFE LIMITED

August 2021

1. Name of doctor/registered nurse who completed the report: _____
2. Name of deceased/insured: _____
3. ID number/date of birth of the deceased/insured: _____
4. Date of death: Y Y Y Y / M M / D D
5. Place of death (town/region): _____
6. Age at death: _____
7. Was the deceased treated by you on a regular basis before his/her death? YES ☐ NO ☐
8. If you answered NO to question (7) please provide details about the deceased's usual medical attendant: _____
9. Where did the death occur:
   HOSPITAL/CLINIC ☐ HOME ☐ OTHER ☐
10. What was the immediate cause of death? _____
    _____
    _____
11. When did the deceased first experience or become aware of the symptoms associated with the immediate cause of death as mentioned in ten (10)?
    Y Y Y Y / M M / D D UNKNOWN ☐
12. When was the diagnosis of the condition that caused the death as mentioned in ten (10) first made?
    Y Y Y Y / M M / D D UNKNOWN ☐
13. In your opinion, for what period (BEFORE the death) was the immediate cause of death as mentioned in ten (10) present/identifiable?
    0 - 30 days ☐ 31- 60 days ☐ >60 days ☐
14. Did any other medical condition contribute in any way to the immediate cause of death as mentioned in ten (10)?
    YES ☐ NO ☐
15. If you answered YES to question fourteen (14) please provide the diagnosis of the condition(s) that contributed to the immediate cause of death:
    _____
16. In your opinion, for what period (BEFORE the death) was the contributory cause of death as mentioned in fifteen (15) present/identifiable?
    0 - 30 days ☐ 31- 60 days ☐ >60 days ☐ No contributory cause present ☐
17. In your opinion, was the death HIV-related in any way?
    YES ☐ NO ☐ UNKNOWN ☐
18. Was the decased ever tested for HIV?
    YES ☐ NO ☐ UNKNOWN ☐
19. What was the result of the HIV test if the deceased was tested?
    POSITIVE ☐ NEGATIVE ☐ UNKNOWN ☐ NEVER TESTED ☐
20. Please state the date of the HIV test: _____
21. Was the death caused by Tuberculosis (pulmonary or extra-pulmonary)?
    YES ☐ NO ☐ UNKNOWN ☐
22. Was the death caused by Pneumonia?
    YES ☐ NO ☐ UNKNOWN ☐
23. Was the death caused by an accident of any kind?
    YES ☐ NO ☐
24. If the death was indeed caused by an accident, how long prior to the death did the accident occur?
    0 - 30 days ☐ 31- 60 days ☐ >60 days ☐ NOT APPLICABLE ☐
25. Was the death a result of participation in any dangerous recreational activity/sport?
    YES ☐ NO ☐
26. Was the death caused by any action on behalf of the deceased himself/herself (i.e. ingestion of lethal substance, drug abuse, suicide by any method)?
    YES ☐ NO ☐ NOT APPLICABLE ☐
27. If the insured was hospitalised in the 3 months prior to his/her death, please state date of admission and date of discharge:
    from Y Y Y Y / M M / D D to Y Y Y Y / M M / D D NOT APPLICABLE
28. Was the post-mortem done?
    YES* ☐ NO ☐ **If yes submit port-mortem report with this report*
29. Kindly attach ALL relevant documentation regarding the medical condition/cause of death.

DATED at _____ this _____ day of _____
SIGNATURE _____ ADDRESS _____
PRINT NAME _____
PRACTICE NUMBER _____

STAMP HERE
Practice/Institution Stamp

When finish filling in form and you details are correct, click the submit button.

Submit Form

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