Death Claim – Attending Physician's Statement

CLEAR FORM

1. Insured information

Clear Section

Name (First/Middle/Last):			
Policy name:			
Policy number:		Certificate number:	
Residential address:			
DOB (dd-mmm-yyyy):	Age:	Gender: ☐ Male ☐ Female	Height:

2. Physician statement

Clear Section

Date you first saw the deceased (dd-mmm-yyyy):	Date you last saw the deceased (dd-mmm-yyyy):
Was death due to: ☐ Suicide ☐ Homicide ☐ Accident ☐ Medical condition ☐ Other:	
Primary cause of death:	
Date of death (dd-mmm-yyyy):	Country of death:
Were there any occupational hazards or personal history connected (remote or proximate) to to the date of death? ☐ Yes ☐ No If "yes", provide details:	
If in a hospital or institution, provide the name and address:	

Details of all medical condition(s) for the past 5 years directly or indirectly contributing to cause of death:

Conditions/Factors	Date of onset of symptoms (dd-mmm-yyyy)	Duration	Treatment/Results

Additional information:

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2. Physician statement (cont'd)

Was an autopsy performed? ☐ Yes ☐ No
If "yes", please complete the table below:

Date of autopsy (dd-mmm-yyyy)	Name of doctor or examiner	Autopsy results

At the time of the accident/death, was the deceased under the influence of any of the following:

Prescription medication: ☐ Yes ☐ No	Illicit drugs: ☐ Yes ☐ No	Alcohol: ☐ Yes ☐ No

Provide names and addresses of all other physicians and practitioners who, to your knowledge, attended the deceased during the past 3 years:

Name of doctor or examiner	Address	Disease or impairment

3. Physician information

Clear Section

Name (First/Middle/Last):	
Name of medical practice:	
Address:	
Phone:	Email:
License number:	Country of license:

Declaration

Physician declaration and signature

By signing this form, I confirm/understand that:

- *The furnishing of forms by BF&M does not constitute an admission that there is any assurance in force.*
- *The information provided above is true and complete and I confirm that I have examined the insured identified in Section 1.*
- *A photocopy of this authorisation is as valid as the original.*

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Declaration (cont'd)

Data protection declaration

By signing this form, I confirm/understand that:

- *I have obtained the insured's consent to enable the lawful transfer of their personal data to BF&M for the processing purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy).*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as Attending Physician) understand and agree with the declaration set out above.

☐ **ACCEPT TERMS**

Name:	
Sign:	Date (dd-mmm-yyyy):

For BF&M official use only

Reports submitted: ☐ Accident Report ☐ Employer's Accident Report ☐ Police Report (required)

Date processed: _____/_____/_____ Admin: _____ Comments: _____