CLAIM FORM 'B'

Life Insurance Corporation (International) B S C (C)
BAHRAIN.

MEDICAL ATTENDANT'S CERTIFICATE

(To be completed by the Medical Attendant in the last illness of the deceased)

In connection with claim under Policy No. .....
on the life of Mr. / Mrs. .....
Address : .....
Occupation : .....

2. (a) Apparent age of the deceased : .....years
   (b) Was he related to you and if so how? : .....
   (c) Description of any marks or physical peculiarities (for identification). .....

3. (a) Time of Death — (a) .....AM / PM
   (b) Date of Death — (b) .....
   (c) Place of death (give exact address) — (c) .....

4. (a) What was the exact cause of death? — (a) Primary cause .....
   Secondary cause .....
   (b) Was it ascertained by Examination after death or inferred from symptoms and appearance during life? — (b) .....
   (c) Period of the disease — (c) .....
   (d) Symptoms reported / noticed — (d) .....
   (e) When were they first observed by the deceased? — (e) .....
   (f) Date of your first consultation — (f) .....
   (g) Period of consultation / treatment by you — (g) .....

5. (a) Were his habits sobre and temperate? — (a) .....
   (b) Have you any reason to suppose or to suspect that disease was caused or aggravated by intemperate habits? — (b) .....

p.t.o.

6.	What other disease or illness (i)Preceded (ii) or co-existed with that which immediately caused his death? Give History of such disease or illness stating:	(i) .....
		(ii) .....
	(a) Date when first observed	(a) .....
	(b) By whom treated	(b) .....
	(c) By whom history was reported to you?	(c) .....
7.	Name and address of the doctors / hospitals who had treated the life assured:	
	(a) before your consultation	(a) .....
	(b) during the treatment by you	(b) .....
8.	(a) Name of deceased's usual Medical Attendant :	(a) .....
9.	When and for what ailment did you treat the deceased during the three years preceding his last illness ?	....
10.	Was any inquest or formal inquiry held regarding the death or was a Post Mortem Examination of the body made? If so by whom, and what was the result or finding?	....
11.	Have you any other information to give or remarks to make in connection with this claim concerning deceased's ailments, habits, mode of living, etc.?	....

I ,..... Medical Attendant of the deceased Mr. / Mrs..... do hereby solemnly declare that the foregoing statements are true and correct to the best of my knowledge and belief that the deceased did not die by his own act.

Dated at ..... this.....day of .....20.....

.....
(Signature of Medical attendant)
Name: .....
Qualification : .....
Postal Address : .....

Witness to signature and identity
of Medical attendant
Signature : .....
Name : .....
Occupation : .....
Postal address : .....