DOCTOR'S CERTIFICATE (FORM "B")

(To be completed by the Doctor / Medical Attendant who last attended the deceased)

Jubilee LIFE INSURANCE

GUIDELINES FOR COMPLETION OF THE FORM

1. Please complete the form in all respects. Do not leave any column blank or incomplete. Please provide details. Use seperate sheets if required.
2. Where boxes have been provided to facilitate your reply, please only tick the relevant box. Leave the remaining boxes unmarked.
3. Please write in neat legible script. Do not use abbreviations, dots, crosses and dashes. Do not overwrite, mutilate, cancel, or delete. In case inadvertently, an error has occurred, then please correct neatly under your full signature.
4. Please sign this form in the same signature & style that you affixed on your CNIC. In case your signature now differs then please provide a set each of three specimen signature in both styles duly attested by the witness / attestor of this form.
5. This form along with any other form / document required to be completed & submitted to the Company should be delivered directly to the Head Office of the Company at the address mentioned at the bottom of this form. The Company shall not be responsible for any form that is not received by it at the Head Office of the Company.

Policy No: _____ Policy Owner: _____

Life Assured: _____

A: PARTICULARS OF THE DECEASED:

1. Name Mr./Ms./Mrs. _____ 2. Age at Death _____

3. Father's / Husband's Name _____ 4. CNIC No. _____

5. Occupation/ Profession _____ 6. Resident of _____

(Nature of duties & details of work performed) *(Locality in city/ Town/ Village)*

7. Appearance & Marks of Identification _____

_____

8. Habits (Known to you) _____

_____

(Habits would include tabacco, alchohal in take & use of drugs)

9. Was the deceased your relative,friend or acquantaince? If **yes** describe the relationship. How long were you acquainted?

_____

B: DETAILS OF DEATH:

1. Incident leading to Death _____

_____

_____

2. Primary Cause of Death _____

_____

_____

(The underlying illness/ medical condition/ injury/ disease etc. that directly caused death- Specific medical terminology to be used)

3. In case death was due to illness, what other medical as well as non-medical factors caused or contributed to the onset or aggravated the disease that caused death? Please provide details & date of occurrance or period the condition persisted.

_____

_____

(list all factors-medical, physical, mental, heriditary, environmental, habits, stress - that in your opinion caused or contributed to the onset of the disease)

4. Was the Cause of death established after death or known during the life-time of the deceased? What were the symptoms?

_____

_____

5. Was the disease /medical condition /symptoms that caused death known to the deceased? If so since when did he know?

_____

(Details are Required - Use a separate sheet if necessary)

_____

6. Date of Death _____ Time of Death _____ Place of Death _____

7. Period(s) of Hospitalization (if any) prior to death for the illness / medical condition / injury that caused death?

From _____ To _____ At _____

From _____ To _____ At _____

From _____ To _____ At _____

(exact date) *(exact date)*

8. Please specify the period you treated the Deceased prior to death? From _____ To _____ ☐ Entire Period

9. Which other Doctor/ Medical Practitioner / Specialist attended / treated the deceased, besides yourself, for the illness / medical condition / injury that caused death? Please provide details.

From _____ To _____ Name & address _____

From _____ To _____ Name & address _____

From _____ To _____ Name & address _____

10. Was the deceased your regular patient or were you ever consulted by him / her for medical advise? ☐ Yes ☐ No
If **Yes** when & for what ailment / medical condition? Please provide record of the deceased's medical history.

11. If not you, then who was the deceased's Personal Medical Attendant / Family Doctor? Please provide the name & address of the Deceased's Regular Doctor. Do you know of the ailment / medical condition the Deceased was being treated for?

12. Are you aware of any physical or mental, illness / disability / deformity / injury / medical condition that the deceased suffered from?
☐ Yes ☐ No If **Yes** what was the ailment and since when was he suffering from it?

13. In the past 5 (five) years was the deceased ever attended by any Doctor or admitted to any Hospital / Clinic for any Physical or Mental, illness / disability / deformity / injury / medical condition? If **'Yes'** please state name & address of Doctor / Medical facility with dates of admission / treatment & details of the health problem / medical Condition.

14. Do you know of any medical tests and examinations that the deceased underwent? If so what were these tests & examinations for? What were the results & findings? When & where were these tests/examinations conducted?

(Name & Address of the Medical Facility(ies) with specific dates are required - Use a separate sheet if necessary)

C: DETAILS OF ACCIDENT/ HOMICIDE/ SUICIDE:

1. Briefly describe the incident and its fatal consequence?

2. What fatal injuries / wounds were sustained? Describe the body systems / organs involved and the damage caused.

3. Was an Autopsy/ Post Mortem conducted? If so what were the results/ findings/Reports? Please provide a copy if available.

4. Was this fatal incident a result of the deceased's Occupation / Avocation / Intemperance or a consequence of any sickness or mental disorder he was suffering from? If yes please provide details.

DOCTOR'S DECLARATION

I, hereby declare that all answers and information provided are true and complete to the best of my knowledge and belief and that no material fact has been withheld.

Name _____
Qualification _____
PMDC No _____
Address _____

Signature with Stamp

Dated at _____ (Place) this _____ (Date) day of _____ (Month) 20 _____ (Year)

This form is to be witnessed and attested by an official of Jubilee Life Insurance Company Limited (formerly New Jubilee Life Insurance Company Limited)of designation not below Assistant Branch Manager / Assistant Manager or by an official of the Government of Pakistan or of the Government of any province of Pakistan under official stamp / seal. The witness / attestor must submit a clear legible copy of his / her CNIC along with this form.

Signature of Attestor / Witness _____ Witnessed at _____ (Place)
Name of Attestor / Witness _____ Dated : _____ (date) (month) (year)
Computerized National Identity Card No. _____
Address of the Attestor / Witness _____

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