NO. 2 PHYSICIAN'S STATEMENT

Alliance Insurance (Public Shareholding Company)
P.O. Box 5501, Dubai, U.A.E. Tel : (9714) 6051111
Fax : 04 6051112, 6051113
Subject to Federal Law No. (9) of 1984 on insurance
& registered under insurance companies registration No. 18/1984.

اللاينس للتأمين (شركة مساهمة عامة)
ص.ب ٥٥٠١ دبي، الامارات اللعربية المتحدة، هاتف: ٦٠٥ ١١١١ (٩٧١٤)
فاكس: ٦٠٥ ١١١٣، ٦٠٥ ١١١٢ - ٠٤
خاطعة لاحكام قانون التأمين الاتحادي (٩) لسنة ١٩٨٤ م.
ومسجلة في سجل شركات التامين تحت رقم ١٩٨٤/١٨

اللاينس للتأمين
ALLIANCE INSURANCE

The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948,
All answers must be in the Physician's handwriting.
In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

1. Full name of deceased	2. Date of death
3. Residence at death	4. Place of death (if hospital or institution, give name)
5. Age at death or date of birth	

6. Cause of death *(Enter only one cause for each of a, b and c)* Disease or condition directly leading to death : *(This does not mean the mode of dying, such as heart failure, asthenia etc. It means the disease, Injury or complication which caused death)* (a)	Interval between onset and death (a)
7. Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a)stating the underlying cause last.)* Due to (b)	(b)
Due to (c)	(c)

8. Other significant conditions: *(Contributing to the death but not related to the disease or condition causing death.)*

9. Date of first attendance in last illness	Date of last attendance in last illness
10. If death was due to accident, suicide or homicide, specify which and describe briefly	Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No If so, by whom and with what findings?
11. Were there any identification marks on the body? ☐ Yes ☐ No If "Yes" give particulars	

12. Have you treated or advised the deceased during the last 5 years, prior to the illness? ☐ Yes ☐ No

13. Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician? or in any other hospital or institution? ☐ Yes ☐ No

If yes to either question, please furnish the following:

Name	Address	Nature of illness or injury	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Date:.....

.....
Signature
Name and Qualifications:.....

.....

INSTRUCTIONS

All answers must be entirely in the Physician's own handwriting.

In the interest of accurate vital statistics, please conform to the International List of the Causes of Death when answering Question 6. External causes (poisons, violence, etc.)

If an injury, describe the accident. If a suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, give type and part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details, as seem desirable should be given below.

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