THE MARITIME FINANCIAL GROUP

MARITIME LIFE (CARIBBEAN) LIMITED

P.O. Box 710, Port of Spain, TRINIDAD

ATTENDING PHYSICIAN'S STATEMENT

(Any fee for this statement is the responsibility of the Claimant)

1. (a) Deceased's name in full: _____

   (b) Residence at death: _____

   (c) Apparent age at death: _____

2. How long had you known the deceased? _____

3. (a) Date of death: _____ (b) Place of death: _____

4. (a) Immediate cause of death: _____ (b) Duration_____

   (c) Contributory cause of death; or any chronic ailments: _____

   ____ _____

   (d) Duration: _____ (e) Date of last attendance: _____

   (f) Was death due to suicide, homicide or accident? _____ (g) If YES, which _____

   (h) Describe briefly: _____

5. (a) Date of first attendance in last illness: _____

   (b) Dates hospitalised – last illness: From: _____ To: _____

6. Give particulars of each condition for which you treated or advised the deceased prior to last illness, with date, duration and result: _____

   _____

   _____

7. (a) Was an Inquest held? Yes ( ) No ( ) (b) Was a Post-Mortem examination made? Yes ( ) No ( )

   (c) If YES, please give particulars: _____

8. Give names and addresses of other physicians or practitioners who attended the deceased during the past three years.

   Name Address Disease or Impairment

   _____

   _____

   _____

   _____

I hereby certify that my answers to the foregoing questions are complete and true to the best of my knowledge and belief.

Signature: _____ Print Doctor's Name and Place Practice Stamp Here:

Address: _____ _____

_____ _____

_____ _____

Date: _____ _____