

2.6 Did the deceased use alcohol or drugs in excess?

Yes No

If "Yes", provide full details.

Empty text box for details of alcohol or drug use.

2.7 Has the deceased ever been tested for HIV antibodies?

Yes No

If "Yes", provide full details.

Date	Results	By whom?

2.8 If known, please provide:

Date of death Age at death Place of death

Immediate cause of death (if known)

Date of start of illness relating to cause of death

Date when deceased first became aware of the illness or any symptoms

2.9 Was an inquest or post mortem held?

Yes No

If "Yes", where was it held?

Findings

Empty text box for findings of inquest or post mortem.

2.10 Diseases or conditions which preceded or co-existed with the immediate cause of death.

Medical conditions/illnesses/injuries	Date commenced	Date consulted

2.11 State in full if any of the following influenced or contributed to the cause of death:

Yes No

	Description/detail	Date of diagnosis/event/commencement
Previous illness or injury		
Family history		
Habits		

2.12 Please provide any other information you may consider relevant.

Empty text box for other relevant information.

Contract number



SECTION 3 MEDICAL ATTENDANT'S DECLARATION

I, the undersigned, a registered medical practitioner, certify to the above information in respect of the deceased and understand that the fee for this report (including supporting documentation) will be paid by Old Mutual in accordance with the tariff laid down by the SA Medical and Dental Council (A1401).

First name(s)

Surname

Practice number

Qualification

Address

Postal code

Contact details

Telephone (Work) Code No Cellphone number

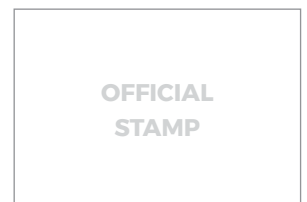
Email address

I certify that I have personally attended to the patient and that all the information provided is complete and correct to the best of my knowledge.

Date

D	D	M	M	Y	Y	Y	Y
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Signature of medical attendant



OFFICIAL
STAMP

Contact us

0860 222 274

contactus@oldmutual.com

PO Box 4512, Cape Town, 8000, South Africa

Contract number

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