Oman Insurance Company Ltd.

P. O. Box 5209 Dubai U.A.E.

PROOF OF DEATH — PHYSICIAN'S STATEMENT

Policy No. _____

1. Name of deceased in full _____

2. Residence at time of death _____ (Street) _____ (City) _____ (State)

3. Age last birthday _____ 4. Date of death _____ Day _____ Month _____ Year

4a. Was death due to: ☐ natural causes ☐ accident ☐ suicide ☐ homicide
If from accident, suicide or homicide, please give details:

5. Immediate cause of death _____ Duration _____ Years _____ Months

6. Contributory cause of death _____ Duration _____ Years _____ Months

6a. Was there an autopsy? ☐ yes ☐ no If yes, by whom and with what result?

7. From known history of the case when did first symptoms become apparent?
_____ Day _____ Month _____ Year 7a. Date of first visit in last illness: _____
Source of history obtained: _____

8. Give dates of treatment for last illness:
At hospital: from _____ 19____ to _____ 19____
At home: from _____ 19____ to _____ 19____
At office or clinic: from _____ 19____ to _____ 19____
Name of hospital _____
Address:

9. What chronic condition or deformity did deceased have, if any?

10. Was deceased ever admitted to any institution, sanitarium, hospital, etc.? ☐ yes ☐ no
If so, for what condition?
Dates of confinement: from _____ 19____ to _____ 19____
Where confined: _____
Address:

11. For what other illnesses had you treated deceased during past five years? Dates of attendance?

12. Give names and addresses of any other physicians or practitioners who attended or advised deceased during past 7 years:

Doctor's Name and Address	Diagnosis	Date Treated

13. Remarks and supplementary data, if any:

Date _____ 19____ Signed _____ M.D.

Address _____ Phone _____