momentum

Medical certificate for death claim

Policy number

The deceased's general practitioner or the medical doctor who treated the deceased during the last ten years, or a medical doctor specified by Momentum, should complete this form in full, in block letters and in black ink.
Momentum will pay the costs for completing this certificate.

Contact details

To submit a claim, follow up on a claim, or to provide us with additional required documentation, you can contact us in any of the following ways. Our office hours are from 8:00 – 17:00.

E-mail: **deathclaims@momentum.co.za**
Fax: **+27 12 675 3947** (Please quote the policy number on the fax.)

Or call us for more information:

Sharecall (South Africa): **0860 44 11 11**
Tel: **+27 12 675 3052**
International: **+27 11 505 1552**

1: Details of the deceased

Title | Initials | First name

Surname

Gender: Male ☐ Female ☐

Date of birth: D D M M Y Y Y Y | Nationality

Permanent identity/passport number | Permanent ID: Yes ☐ No ☐

Was the deceased a member of a medical aid? Yes ☐ No ☐

Name of medical aid

Medical aid number

Name of hospital/clinic

Hospital/Clinic file number

2: Medical history of the deceased

I certify that I treated the deceased in my professional capacity from D D M M Y Y Y Y to D D M M Y Y Y Y

Patient file number

Did you treat the deceased before his/her last illness? Yes ☐ No ☐

Nature of any complaints for which the deceased consulted the practice:

Date	Symptoms	Diagnosis (BP reading, lab, test reults)	Treatment

2: Medical history of the deceased (continued)

Was the deceased ever hospitalised or admitted to any institution or clinic? Yes ☐ No ☐

If “yes”, provide full details:

Reason	Hospital/Institution	Hospital/Clinic file number	Date
			M M Y Y
			M M Y Y

Did the deceased consult any other doctors/specialists/hospital or institution? Yes ☐ No ☐

If “yes”, provide full details:

Reason	Hospital/Institution	Hospital/Clinic file number	Date
			M M Y Y
			M M Y Y
			M M Y Y
			M M Y Y
			M M Y Y

Provide copies of all reports.

Did the deceased ever use intoxicating liquor, narcotics, drugs and/or substances? Yes ☐ No ☐

If “yes”, provide full details

Is there any reason to believe that the insured life’s death is in any way, whether direclty or indirectly, entirely or partially, related to AIDS or HIV infection? Yes ☐ No ☐

If “yes”, provide full details

Has the insured life ever been tested for HIV antibodies? Yes ☐ No ☐

If “yes”, complete the following:

Date	By whom	Results
M M Y Y		
M M Y Y		

3: Details of death

Date of death D D M M Y Y Y Y

How old was the deceased at death?

Place of death

Main cause of death

Date of commencement of illness relating to cause of death D D M M Y Y Y Y

Date when deceased first became aware of it or any symptoms D D M M Y Y Y Y

Was a postmortem conducted? Yes ☐ No ☐

If “yes”, provide full details:

Was an inquest or post mortem held? Yes ☐ No ☐

If “yes”, where was it held?

Findings:

Related illnesses which existed prior to or may be related to the cause of death:

Condition/illness	**Date commenced**	**Date consulted**
	D D M M Y Y	D D M M Y Y
	D D M M Y Y	D D M M Y Y
	D D M M Y Y	D D M M Y Y

3: Details of death (continued)

Did any of the following influence or contribute to the cause of death | Previous illness or injury ☐ | Family history ☐ | Habits ☐

If "yes" to any of the above, provide full details:

Provide details on any other information which may be related to the cause of death:

4: Details of doctor

Title | Initials | First name

Surname

Physical address

Postal code

Postal address

Postal code

Telephone number | Fax number

Cellphone number | Practice number

Qualifications

Please indicate amount based on the tariff of fees

I state that the answers given in this certificate are correct to the best of my knowledge and belief.

Signed at

Signature of medical doctor | **Date** D D M M Y Y Y Y

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