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Policy Number

AXA China Region Insurance Company (Hong Kong) Limited
AXA China Region Insurance Company Limited
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DEATH CLAIM FORM II

Important note:
Your patient is insured with us against the occurrence of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement

1. PATIENT'S INFORMATION

Name of patient (Insured)		HKID Card/ Passport No.	
Did the patient have any of the following habits? If yes, please provide the duration and consumption details	☐ Yes ☐ No		
	☐ Smoking ☐ Drugs taking ☐ Drinking Duration _____ Consumption Per Day _____		

2. ABOUT HEALTH HISTORY RELATED TO DEATH

Date of first consultation	dd ____ mm ____ yyyy _____	Name of the Doctor referral, if any	
Symptom(s)/complaint(s) presented during the first consultation		How long had the patient been experiencing these symptoms before the first consultation	

3. ABOUT THE DEATH

Date of death	dd ____ mm ____ yyyy _____	Place of death	
Immediate cause of death			
If the death was related to an accidental nature, please specify details			
Date and time of the incident	dd ____ mm ____ yyyy _____ hh ____ mm ____ ss ____		
Describe how the incident happened			
Was the death secondary to a recurrent or chronic illness? If Yes, what and for how long?	☐ Yes ☐ No		

CHK1DEATH2

LFC035-2511

Were any factors below contributing to the death?			
Previous illness or injury	☐ Yes	☐ No	Please state if any other contributing factors?
Life style (Drugs, alcohol, recreational activities)	☐ Yes	☐ No	
Occupation	☐ Yes	☐ No	
Hepatitis virus carrier	☐ Yes	☐ No	
HIV related	☐ Yes	☐ No	

4. ABOUT HEALTH HISTORY

Had the patient suffered from any other major, chronic or congenital disease? If Yes, please state the details including the date the condition was first diagnosed	☐ Yes ☐ No
Is there any information about the past health of patient not mentioned in the above questions? If Yes, please state the details	☐ Yes ☐ No

Date of doctor Consultation or Hospital admission	Name of doctor or hospital	Complaints and Symptoms	Diagnosis	Treatments given (please state name of surgical procedure if performed or to be performed)
dd _____ mm _____ yyyy _____				
dd _____ mm _____ yyyy _____				

5. DECLARATION AND AGREEMENT

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician	Contact tel. no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date
	dd _____ mm _____ yyyy _____