

ATTENDING PHYSICIAN'S STATEMENT NOTIFICATION OF DEATH

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MetLife Europe d.a.c.
Irská společnost s reg. č. 415123
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Please complete the form by hand (not in black ink) or electronically.

First name and surname of the Insured Date of birth

Date of death Place of death

Cause of death (diagnosis classification number and description of injury/illness)

Date of injury/initial symptoms of illness Place of injury

Date of initial treatment due to injury/illness Name of the physician and address of the healthcare facility

Previous pathological conditions affecting the Insured's death:

Was the Insured under influence of alcohol or other addictive substances at the time of death? yes no

In case of alcohol, state the blood-alcohol test result:

Was the Insured's death investigated by the police? yes no

Did the Insured's death occur due to suicide or murder? yes no

If so, state circumstances:

Was a forensic or clinical autopsy performed? yes no

If so, provide the address of the facility:

If you were the Insured's attending physician prior to his/her death, please provide a brief extract from medical documentation for the last five years on the back page of this form. If the Insured was treated by other physicians, please provide their names and addresses:

Other information from the attending physician:

Please complete the following page.



