Allianz PNB
LIFE INSURANCE

Policy No. ☐☐☐ ☐☐☐ ☐☐☐

ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIM

IMPORTANT NOTICE

This statement must be made by the physician in attendance during the last illness of the deceased and/or his/her regular physician/s. If more than one physician was employed, the statement of each must be furnished upon on separate forms, which will be sent if required. When an autopsy has been made by order of the Court, a copy of the verdict, and of the evidence, upon which it was based duly certified, must be furnished. Indefinite terms as heart failure, exhaustion and the like are to be avoided unless full details are added. Where the spaces set apart for the answers are too small, such details as seem desirable may be given on a separate sheet.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent present or use the same, or to allow it to be presented in support of any claim.

GENERAL INFORMATION

Full Name of the deceased _____

Date of birth of the deceased _____ Last occupation of the deceased _____

Are you related to the deceased by blood or consanguinity? _____ If yes, how? _____

Are you the regular physician of the deceased? _____ If yes, since when? _____

Did any other physician attend to the deceased? _____ If yes, please give details below:

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

DETAILS OF DEATH

Date of death _____ Place of death _____

What was the immediate cause of death? _____

Was an autopsy performed? _____ If yes, what were the findings? _____

_____

Did you personally see the remains of the deceased? _____

Date and hour of your first and last visits to the deceased _____

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DETAILS OF THE ILLNESS

Describe the nature and symptoms of the insured's illness/disease _____

_____

Date the symptoms first occurred _____

What were the first indications of failing health? _____

Details of previous consultations

Date of Consultation	Illness / Diagnosis	Procedure / Operation Done	Prescribed Medication

From what other illness or disease did the insured suffer? Please give, as nearly as you can, the duration of each one

_____

_____

Did previous illness, family history or habits, in any way, predispose the deceased to the cause of death? _____ If yes, please explain.

_____

_____

PRESCRIBED MEDICINES &/OR TREATMENT

Physician's Name, Address & Contact No.	Nature of Injury/Treatment	Prescribed Medicines &/or Treatment

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DETAILS OF CONSULTATION/S & HOSPITAL CONFINEMENT/S

Name, Address & Contact No. of Hospital, Clinic or Institution	Attending Physician (Please include Surgeons, if any)	Inclusive Date of Consultation/s and/or Confinement	Nature of Injuries	Procedure/ Operation/s Done (Please five inclusive dates, if any)

Do you have similar coverages with any other company? ____Yes / ____No. If yes, please give details:

Company Name:_____ Policy No._____ Benefit Type/ Plan_____

Have you filed claims for these benefits? ____Yes / ____No

DETAILS OF TOTAL & PERMANENT DISABILITY

What was your occupation and designation on the date of the onset of your present disability? _____

What were the activities related to your work, routine functions and/or job description? _____

When was your last day at work? _____ When was your condition diagnosed? _____

When was the onset of your disability? _____

Has your disability existed continuously since then? If not, please explain. _____

What injuries or illnesses have you had prior to your disability? _____

Indicate your level of education (degrees, vocational or technical courses attained) and other occupation for which you are skilled.

Are you presently undergoing or have you undergone therapy sessions? _____

If yes, please provide details on the type of therapy, duration, therapists and improvements noted. _____

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Having been duly sworn, I hereby depose and say that all the statements in the foregoing answers are true and full, to the best of knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at _____, this_____ day of _____, 20_____.

_____
Name and Signature of Witness

_____
Printed Name & Signature of Attending Physician
License No. _____

_____
Address and contact no.

_____
Address and contact no.

On this _____ day of _____, 20_____ personally appeared before me the above named_____, who being by me duly sworn, deposed that the answers to the above questions are full and true, to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

Affiant exhibited to me his/her Residence Certificate No. _____ issued at_____ on _____.

NOTARY PUBLIC

Doc.No._____;
Page No._____;
Book No._____;
Series of _____.

THIS STATEMENT MUST BE MADE BEFORE A NOTARY PUBLIC OR OTHER OFFICER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A MUNICIPAL JUDGE OR BY THE CLERK OF COURT OF RECORD.