

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 _____

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? _____

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 |
|---|----------------------------|-------------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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) |
|--|---|---|--------------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

DETAILS OF THE ACCIDENT OR VIOLENT INCIDENT

Date and Time of Accident/Incident _____

Place of Accident/Incident _____

Extent of Injuries _____

Was the insured under the influence of alcohol or medication? _____ If yes, to what extent? _____

DECLARATIONS

Name of Attending Physician _____

License No. _____

Field of Specialization _____

Address _____

Contact Nos. _____

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_____.

Signature of Attending Physician