Policy Number(s)

Death Claim Form
(Attending Physician's Statement)

Important Notes:

1. This form is to be accomplished by the Attending Physician.
2. Please write legibly in BLOCK LETTERS. Do not sign on a blank form.
3. Please shade the circle to indicate your choice(s).

FOR OFFICE USE ONLY

Date Received:

Time Received:

Receiving Dept./Office:

FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's name:

FE/Advisor's mobile number:

1. Claim Types:

◯ Death Benefit ◯ WP/WPDD

2. General Information:

Full Name of Deceased (as shown in Identification Document)

Date of Birth: (yyyy/mm/dd)

3. Your Association with the patient:

Are you related to the patient? ◯ Yes ◯ No **If "Yes", please provide details below:**

Relationship:

No. of years you have known the patient

Are you the attending physician of the patient prior/during his/her death? ◯ Yes ◯ No

If "Yes", please provide details below:

Date when you first attended the patient

Chief complaints of the patient

4. Particulars of Death:

Date of Death: (yyyy/mm/dd)

Place of Death:

Immediate Cause of Death:

If death is by natural cause/illness, please provide details below:

Illness the deceased suffered from before death:

Date symptoms first noticed:

Date of first consultation:

If death is by violent incident, please provide details below:

Nature of violent incident:

◯ Accident ◯ Murder
◯ Homicide ◯ Suicide

Date of incident:

Place of incident:

Please state below the details of your diagnosis and medical treatment given to the patient

Complete Diagnosis:

Treatment:

Is Death secondary to a recurrent or a chronic Illness? ◯ Yes ◯ No

If "Yes", please provide details below:

Name the condition and/or signs and symptoms

Will there be or was there an autopsy made on the body of deceased? ◯ Yes ◯ No

If "Yes", please provide details below:

Date of Autopsy:

Results: (if autopsy has been already made)

Place of Autopsy:

Did other physicians attend the patient prior/during his/her death? ◯ Yes ◯ No

If "Yes", please provide details below:

Name:

Contact Details:

5. Your known Health History of the Deceased:

Recent consultations and hospital confinements

Date: (yyyy/mm/dd)	Name and Address of the Hospital/Clinic:	Diagnosis and Treatment

6. Declarations:

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:

Signature:

Place of Signing:

Date of Signing: (yyyy/mm/dd)

Field of Specialization:

License No:

Clinic Address:

Mobile No.:

Clinic Tel. No.: