ATTENDING PHYSICIAN'S STATEMENT DEATH CLAIM

IMPORTANT: All answers must be entirely in the Physician's own handwriting.
If more than one physician was employed, the statement of each must be furnished upon separate forms, which will be sent if required.
Where spaces provided for the answers are too small, such details as seen desirable should be given on the reverse side of this form.

1.	Full Name of deceased	
2.	Residence of deceased	
3.	Occupation of deceased at death	
4.	How long had you known the deceased?	
	How long did you attend the deceased?	
5.	Did you attend or were you consulted by the deceased before the last illness / injury? If yes, when and for what illness / injury? Please provide details.	
6.	a. Date of Death	
	b. Place of Death	
7.	What was the immediate cause of death?	
8.	When were you first consulted for the illness / injury which either directly or indirectly caused death? a. Give date of last visit b. Who consulted you (Please specify if deceased, relatives or others)	
9.	How long did the deceased suffer from this illness / injury? Please provide basis/details for your answer.	
10.	What are the contributory causes of death? (Please provide details of each)	
	Disease / Injury	Duration
11.	Please give names of other physicians / practitioner who to your knowledge attended the deceased during the last illness / injury.	
	Name of Physician / Hospital / Institution	Disease / Injury : Dates Attended
12.	Was there any special connection (remote or proximate) between the death and personal history, habits, occupation or residence of the deceased? If yes, please state which and give particulars.	
13.	Was death due to accident, homicide or suicide? If yes, please provide details.	
14.	Was deceased under the influence of liquor or prohibited drugs when the accident / homicide / suicide happened? If yes, please provide details.	
15.	Was there an official inquiry as to cause of death or post-mortem examination on the body of the deceased? If yes, please provide details.	

DECLARATION:
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION:
I further authorize the Medical Director or any of his/her authorized representatives to furnish PHILIPPINE LIFE FINANCIAL ASSURANCE CORPORATION or its authorize representatives all medical records of the deceased/patient. A photographic copy of this authorization is valid as the original.

_______________________________________ ____________________
Signature over Printed Name of the Attending Physician Date

Specialization: ______________________________
License No: ________________________________
Contact Numbers: ___________________________