# Attending Physician's Statement
## Death Claim

NOTE: Fill out ☐ with block letters.
Put ☒ on the tick boxes representing options.
Please use reverse side for answers requiring additional information but not indicated on this questionnaire.
Identify your answers with the corresponding numbers.

## DECEASED'S INFORMATION

1. a. Full name of the deceased:

*Last Name* | *First Name* | *Middle Name*

b. Last Residence of the deceased:

## PHYSICIAN'S OBSERVATIONS

2. a. From physical findings & appearances, what would you judge to be the age of the deceased?

b. What identifying marks have you noticed in the body of the deceased, say a mole or scar on any part of the body?

c. Do you know the deceased personally? ☐ Yes ☐ No

3. a. Did you attend to the deceased during his last illness? ☐ Yes ☐ No

b. If yes, for what disease?

c. When was your first attendance and what was the deceased's complaint? *mm / dd / yyyy*

d. What was your diagnosis then and what treatment did you give to the deceased?

e. Did you inform the deceased of your diagnosis? ☐ Yes ☐ No

f. How many times did you attend to the deceased during his last illness?

g. Who called you or accompanied the disease for treatment?

4. a. What disease was the immediate cause of death?

b. What were the first indications of failing health?

c. Give date and hour when they were first noticed by deceased? *mm / dd / yyyy* *hh / mm* ☐ AM ☐ PM

d. For how long before death was the deceased confined to house or prevented from attending to business?

From *mm / dd / yyyy* To *mm / dd / yyyy*

e. For how long was the deceased bed-ridden?

From *mm / dd / yyyy* To *mm / dd / yyyy*

5. a. Did you attend to the deceased for any other illness? ☐ Yes ☐ No

b. If yes, for what disease?

c. When was the onset of the illness? *mm / dd / yyyy*

d. When was your other attendance and for what disease?

| Date | Disease or Illness |
|---|---|
| *mm / dd / yyyy* | |
| *mm / dd / yyyy* | |
| *mm / dd / yyyy* | |
| *mm / dd / yyyy* | |
| *mm / dd / yyyy* | |

e. Did you inform the deceased of your diagnosis? ☐ Yes ☐ No

f. Other physicians who attended to the deceased for any other illness the insured suffered:

| Name of Physician | Address | Date | Nature of Disease |
|---|---|---|---|
| | | mm / dd / yyyy | |
| | | mm / dd / yyyy | |
| | | mm / dd / yyyy | |

g. Other hospitals or institutions where deceased was confined for any cause:

| Name of Hospital | Address | Date | Nature of Disease |
|---|---|---|---|
| | | mm / dd / yyyy | |
| | | mm / dd / yyyy | |
| | | mm / dd / yyyy | |

6. a. Did you personally see the remains of the deceased? ☐ Yes ☐ No

b. What apparent or external signs (contusion, abrasions, etc.) have you noticed on the body?

c. Was the death due to ☐ suicide ☐ homicide ☐ murder ☐ accident?
If yes, describe briefly.

d. Date of death: mm / dd / yyyy Place of death:

e. Was there an autopsy or other post-mortem examination made on the body of the deceased? ☐ Yes ☐ No
Please describe briefly.

## PHYSICIAN'S DECLARATION

I, _____
*Physician's Name in Full: Last Name, First Name, Middle Name*

a graduate of _____
*Medical College*

in the year _____ with License No. _____

**hereby truthfully certify that the answers given above are full, complete and true.**

**Witnessed by:**

_____
**Physician's Signature**

_____
**Printed name and signature of witness**

**Date Signed:** _____
*mm / dd / yyyy*

**Place Signed:** _____

**Mobile Number:** _____
*(09XX-XXXXXXX)*

**Clinic Address:** _____

**Clinic Hours:** _____