



Policy Number(s)

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# 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).

### 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:

<p><b>Date of Death: (yyyy/mm/dd)</b> <input type="text"/></p> <p><b>Place of Death:</b> <input type="text"/></p>	<p><b>Immediate Cause of Death:</b> <input type="text"/></p>
<p><b>If death is by natural cause/illness, please provide details below:</b></p> <p>Illness the deceased suffered from before death: <input type="text"/></p> <p>Date symptoms first noticed: <input type="text"/></p> <p>Date of first consultation: <input type="text"/></p>	<p><b>If death is by violent incident, please provide details below:</b></p> <p>Nature of violent incident:  <input type="radio"/> Accident      <input type="radio"/> Murder  <input type="radio"/> Homicide      <input type="radio"/> Suicide </p> <p>Date of incident: <input type="text"/></p> <p>Place of incident: <input type="text"/></p>

**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:

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:

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:

Name the condition and/or signs and symptoms

### 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.:**