

ATTENDING PHYSICIAN'S STATEMENT – DEATH CLAIM

Note: Kindly submit this form to InLife Benefits Insurance Company, Inc duly completed by a qualified and registered physician at the expense of the claimant.

DECEASED PATIENT'S DETAILS

Last Name		First Name		Middle Name	
Address					
Date of Birth (MM/DD/YYYY)	Place of Birth			Age	Status
Date of Death	Place of Death				
Cause of Death					
Immediate Cause					
Antecedent Cause					
Underlying Cause					
Other significant factors contributing to death					
How long has the deceased been your patient?					
If you attended to the deceased during the last illness, please answer the following questions:			Diagnosis		
Date of first consultation					
Initial signs and symptoms noticed by the deceased					
Duration of the disease or illness and inclusive date/s of treatment					
Did you personally inform the deceased of your findings and diagnosis? If so, when?					

PLEASE GIVE DETAILS OF THE DECEASED'S PREVIOUS HEALTH CONDITIONS TO WHICH YOU ATTENDED PRIOR TO LAST ILLNESS:

Date of Attendance	Diagnosis	Treatment/Procedure

How long before death was the deceased confined to house or prevented from attending to business or occupation?

How long was the deceased bedridden?

ARE YOU AWARE OF ANY OTHER CONSULTATION OR CONFINEMENT OF THE DECEASED FOR ANY ILLNESS OR INJURY? IF SO, PLEASE PROVIDE INFORMATION BELOW:

Date of Attendance	Name of Physician/Address	Medical Institution/Address	Diagnosis/Treatment/Procedure



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Philippines, Inc.

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Did you personally see the remains of the deceased?

Was there an autopsy or any other post-mortem examination made on the body of the deceased?

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I HEREBY CERTIFY that the above statements are true and complete to the best of my knowledge and belief

Dated at _____ this _____ day of _____ 20 _____

SIGNATURE OVER PRINTED NAME

QUALIFICATION

ADDRESS

CONTACT DETAILS

SUBSCRIBED AND SWORN to me this _____ day of _____, 20 _____ by the
above claimant who exhibited to me his/her Residence Certificate No. _____ issued at _____ on _____
_____.

Doc No. _____ Book No. _____
Page No. _____ Series of _____
_____ My Commission expires on _____

NOTARY PUBLIC