BDO life®

Attending Physician's Statement - Death Claim

This form must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the claimant.

1. PATIENT/INSURED'S DETAILS

a. Name : ____
Last Name First Name Middle Name

b. Address : ____

c. Date of Birth : ____________ Place of Birth : ____________ Age: ______ Status: ____________

d. Date of Death : ____________ Place of Death : ____________________

e. Cause of Death : ____

f. Have you attended the insured prior to his/her death? ____________ If Yes, please indicate the following:

f.1 Date of first consultation ____________________

f.2 Initial signs and symptoms noticed by the insured ____________________________

f.3 Diagnosis ____

f. 4 Duration of the disease or illness and inclusive date(s) of treatment ____________________

g. Did you personally inform the insured of your findings and diagnosis, if so, when? ____________________

h. Please give details of the insured's other previous health condition which you attended prior to last illness, if any:

Date of Attendance	Diagnosis	Treatment/Procedures

i. How long before death was the insured confined to a medical facility or house, or prevented from attending to business or occupation?____________________ How long was the insured bedridden? ____________________

j. Are you aware of any other consultation or confinement of the insured for any illness or injury? If you are, please provide information below:

Date of Attendance	Medical Institution and Address	Medical Institution and Address	Diagnosis/Treatment/ Procedure

k. Did you personally see the remains of the insured? ____________________ Was autopsy performed? ____________

Please enclose copies of medical reports together with any test results or similar evidence in your possession to support the validity of the claim.

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at ______________________________ this ____________ day of ______________________20________.

Signature Over Printed Name of Physician	Specialty
Address	Contact Number (s)
PRC Number	PTR Number

SUBSCRIBED AND SWORN to before me by Dr. ____ at ____________________________. Affiant exibited to me by his/her ID No. ____________________ issued at ________________________ on ________________________, valid until ________________________.

NOTARY PUBLIC

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