

## Attending Physician's Statement Death Claim

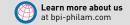
NOTE: Fill out with block letters.  Put x on the tick boxes representing options.  Please use reverse side for answers requiring additional information but not indicated on this questionnaire.  Identify your answers with the corresponding numbers.							
DECEASED'S INFORMATION							
1. a. Full name of the deceased:							
Last Name	First Name	Middle Name					
b. Last Residence of the deceased:	Thachane	Triddle Harrie					
PHYSICIAN'S OBSERVATIONS							
2. a. From physical findings & appearan	ces, what would you judge to be the age	e of the deceased?					
b. What identifying marks have you no	ticed in the body of the deceased, say a	mole or scar on any part of the body?					
c. Do you know the deceased persona							
3. a. Did you attend to the deceased duri	ng his last illness? Yes No						
b. If yes, for what disease?							
c. When was your first attendance and	d what was the deceased's complaint?	mm / dd / yyyy					
d. What was your diagnosis then and v	what treatment did you give to the dece	ased?					
e. Did you inform the deceased of you	r diagnosis?						
f. How many times did you attend to t	he deceased during his last illness?						





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a. What disease was the immediate cause of death?							
h \\\/\bar\\\	a Alica Charak in disability and facility						
b. What wer	e the first indications of faili	ng neattn?					
c. Give date and hour when they were first noticed by deceased?							
	c. Olve date and flour when they were in stribilitied by deceased:		mm / dd / yyyy	hh/mm PM			
d. For how lo	ong before death was the de	ceased confined to house	or prevented from attend	ing to business?			
From	mm / dd / yyyy	То	mm / dd / yyyy				
e. For how l	ong was the deceased bed-r	idden?		_			
From	mm / dd / yyyy	То	mm / dd / yyyy				
a Did you at	tend to the deceased for any	y other illness? Yes	No	_			
-	what disease?	y other ittless: Tes	140				
D. 11 yc3, 101	What discuse:						
c. When was	s the onset of the illness?	mm / dd / yyyy					
	s the onset of the illness?		Disease or Illness				
	s the onset of the illness? s your other attendance and Date		Disease or Illness				
	s the onset of the illness?		Disease or Illness				
	s the onset of the illness? s your other attendance and Date		Disease or Illness				
	s the onset of the illness?  s your other attendance and  Date  mm/dd/yyyy  mm/dd/yyyy		Disease or Illness				
	s the onset of the illness? s your other attendance and Date  mm/dd/yyyy		Disease or Illness				
	s the onset of the illness?  s your other attendance and  Date  mm/dd/yyyy  mm/dd/yyyy		Disease or Illness				
	s the onset of the illness?  s your other attendance and  Date  mm/dd/yyyy  mm/dd/yyyy  mm/dd/yyyy		Disease or Illness				







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

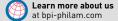
Name of Physician	Address	Da	te	Nature of Disease				
			4 /					
		mm / do	1 / yyyy					
		mm / do	d / yyyy					
		mm / do	d / yyyy					
g. Other hospitals or institutions where deceased was confined for any cause:								
Name of Hospital	Address	Da	te	Nature of Disease				
		mm / do	d/vvvv					
			. ,,,,,					
		mm / do	d / yyyy					
		mm / do	д / уууу					
a. Did you personally see the re	mains of the deceased?	Yes No						
h What annarent or external sid	b. What apparent or external signs (contusion, abrasions, etc.) have you noticed on the body?							
т. т.т.а. аррагот от ототталого	, (							
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.								

6.











## PHYSICIAN'S DECLARATION ١, Physician's Name in Full: Last Name, First Name, Middle Name a graduate of Medical College with License No. in the year 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:**

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**Clinic Hours:** 



