

ATTENDING PHYSICIAN'S STATEMENT FORM (Group Policy Death Claim)

Note: This form is to be accomplished by the Attending Physician and is part of the claim requirements. Kindly use **BLACK INK** and write in **BLOCK LETTERS** and put a check on the applicable boxes. Indicate **N/A** if a question is not applicable.

Policy Number	Name of Policyholder
Name of Insured (Last Name, First Name, Middle Name)	

PHYSICIAN'S INFORMATION

Name of Physician (Last Name, First Name, Middle Name)	
Hospital Name & Address (No., Street, Bldg, Brgy, Town/City, Province/Region, Country)	
Email Address	Mobile Number

DETAILS OF CLAIM

Name of Deceased (Last Name, First Name, Middle Name)		
Date of Death (MM/DD/YYYY)	Place of Death	Cause of Death
Is the death due to accident, suicide or homicide? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify and describe below briefly.		
How long have you known the deceased?	What were the first symptoms noticed?	
What was your diagnosis?	Were you able to inform the deceased of your diagnosis? <input type="checkbox"/> YES <input type="checkbox"/> NO	How long did the deceased suffer from the ailment?
Will there be or was there an autopsy made on the body of the deceased? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", please provide details below: Date of Autopsy (MM/DD/YYYY): _____ Place of Autopsy: _____ Results (if autopsy has been already made) _____		

Your known Health History of the deceased in the past three years:

Symptoms	Name and Address of the Hospital/Clinic	Date (MM/DD/YYYY)	Diagnosis/Treatment



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Physicians to your knowledge who attended to the deceased for any illness?

Name of Physician	Name and Address of the Hospital/Clinic	Date (MM/DD/YYYY)	Reason/Treatment

Other hospitals/clinics to your knowledge where the deceased was treated:

Name and Address of the Hospital/Clinic	Date (MM/DD/YYYY)	Diagnosis

DECLARATIONS AND AUTHORIZATION

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

I authorize MaxiLife's Medical Doctor or any of his authorized representative/s or other person/s in MaxiLife's employ or under contract with MaxiLife to request and/or secure from me or any medical practitioner/or its duly authorized representatives to request and secure any or all information, records or documents which are available from my medical practitioner/facility/hospital/clinic or any entity, the medical records of the above-named patient/insured. I agree that a photographic copy of this authorization should be valid as the original.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same or to allow it to be presented in support of any claim.

Signature over Printed Name of Physician

PRC Number

Specialization

Date of Signing

Place of Signing