Allianz PNB LIFE INSURANCE

ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIM

Policy No. ___ ___ ___

IMPORTANT NOTICE

This statement must be made by the physician in attendance during the last illness of the deceased and/or his/her regular physician/s. If more than one physician was employed, the statement of each must be furnished on separate forms, which will be sent if required. When an autopsy has been made by order of the Court, a copy of the verdict, and of the evidence, which it was based duly certified, must be furnished. Indefinite terms as heart failure, exhaustion and the like are to be avoided unless full details are added. Where the spaces set apart for the answers are too small, such details as seem desirable may be given on a separate sheet.

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 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 present or use the same, or to allow it to be presented in support of any claim.

GENERAL INFORMATION

Full Name of the deceased ______________________________

Date of birth of the deceased ______________ Last occupation of the deceased ______________

Are you related to the deceased by blood or consanguinity? ________ If yes, how? ______________

Are you the regular physician of the deceased? ________ If yes, since when? ______________

Did any other physician attend to the deceased? ________ If yes, please give details below:

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

DETAILS OF DEATH

Date of death ______________ Place of death ______________

What was the immediate cause of death? ______________________________

Was an autopsy performed? ________ If yes, what were the findings? ______________

____

Did you personally see the remains of the deceased? ______________________________

Date and hour of your first and last visits to the deceased ______________________________

DETAILS OF THE ILLNESS

Describe the nature and symptoms of the insured's illness/disease ______________________________

____

Date the symptoms first occurred ______________________________

What were the first indications of failing health? ______________________________

From what other illness or disease did the insured suffer? Please give, as nearly as you can, the duration of each one

____

Did previous illness, family history or habits, in any way, predispose the deceased to the cause of death? ________ If yes, please explain.

____

PRESCRIBED MEDICINES &/OR TREATMENT

Physician's Name, Address & Contact No.	Nature of Injury/Treatment	Prescribed Medicines &/or Treatment

DETAILS OF CONSULTATION/S & HOSPITAL CONFINEMENT/S

Name, Address & Contact No. of Hospital, Clinic or Institution	Attending Physician (Please include Surgeons, if any)	Inclusive Date of Consultation/s and/or Confinement

Nature of Injuries	Procedure/ Operation/s Done (Please give inclusive dates, if any)

DETAILS OF THE ACCIDENT OR VIOLENT INCIDENT

Date and Time of Accident/Incident ____________________

Place of Accident/Incident ____________________

Extent of Injuries ____________________

Was the insured under the influence of alcohol or medication? ________ If yes, to what extent? ____________________

____

DECLARATIONS

Name of Attending Physician ____________________

License No. ____________________

Field of Specialization ____________________

Address ____________________

Contact Nos. ____________________

I hereby depose and say that all the statements in the foregoing answers are true and full, to the best of my knowledge and belief, and that there are no material facts in the case which are not disclosed.

Signed at ____________________ this ______________ day of ______________ 20_____.

____
Signature of Attending Physician