



ATTENDING PHYSICIAN'S STATEMENT

(BEFORE ACCOMPLISHING THIS FORM, PLEASE READ INSTRUCTIONS AT THE BACK HEREOF)

This is in proof of my Medical Attendance to _____, under Certificate No. _____, Master Policy No. _____ insured by Etiqa Philippines.

I, _____, a graduate of _____ in the year _____, with residence address at _____, hereby truthfully and voluntarily state as follows:

| | |
|---|--|
| <p>1. (a) Full Name of Deceased _____</p> | <p>(b) Residence at time of death _____</p> |
| <p>(c) From physical findings and appearances what would you judge to be the age of the deceased? _____</p> | <p>(d) What identifying marks have you noticed in the body of the deceased? _____</p> |
| <p>2. (a) Do you know deceased personally? _____</p> | <p>(b) How long have you known the deceased? _____</p> |
| <p>(c) How many times did you attend to deceased? _____</p> | <p>(d) When was your first attendance? _____</p> |
| <p>(e) What were deceased's complaints in your first attendance? _____</p> | <p>(f) Who called you or accompanied the deceased for treatment? _____</p> |
| <p>(g) Did you informed deceased of your diagnosis? _____</p> | |
| <p>3. (a) Did you attend to deceased during last illness? _____</p> | <p>(b) If so, for what disease? _____</p> |
| <p>(c) What disease was the immediate cause of death? _____</p> | <p>(d) How long did deceased suffer from this disease?(give details) _____</p> |
| <p>(e) What were the first indications of failing health? _____</p> | <p>(f) For how long before death was deceased confined to house or prevented from attending to business? _____</p> |
| <p>(g) Give date and hour when they were noticed by deceased. _____</p> | <p>(h) For how long was deceased bedridden? _____</p> |



4. (a) From what other disease, if any did _____ (b) Give as nearly as you can the duration of each.
 deceased suffer? _____

(c) Give below particulars of each condition for which you treated or advised deceased prior to last illness.

| Disease/Illness | Date | Duration | Result |
|-----------------|-------|----------|--------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

(d) Give names and addresses of all other physician's and practitioners who, to your knowledge attended to the deceased during the past three years.

| Name | Address | Disease/Impairment & Date |
|-------|---------|---------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

5. (a) Did you personally see the deceased? _____
 (b) Date & Place of Death _____
 (c) Was there an autopsy or other past post-mortem examination made on the body of the
 deceased? _____

6. Would you swear to the truth of the foregoing? _____

Dated at _____ this _____ day of _____, _____.

 PRINTED NAME AND SIGNATURE
 OF WITNESS

 SIGNATURE OVER PRINTED NAME OF
 ATTENDING PHYSICIAN

Address of Witness

License Number



INSTRUCTIONS : ALL ANSWERS MUST BE ENTIRELY IN THE PHYSICIAN'S OWN HANDWRITING

The claimant is responsible for the submission of this Attending Physician's Statement which should be accomplished by every physician who attended to the deceased during or before last illness.

If more than one physician attended to the deceased, each physician must accomplish the Attending Physician's Form, which will be furnished by the Company upon claimant's request.

The physician who fills this form will facilitate the settlement of the claim by giving answer to pertinent questions, a full statement of each pathological process, especially as to its duration, indefinite terms are to be avoided unless full details are added.

If there was an autopsy made on the body of the deceased, a certified copy of the autopsy report should be secured by the claimant and submit it along with this form.

Where the spaces provided for the answers are not enough, pertinent details may be given on, under **ADDITIONAL REMARKS**.

ADDITIONAL REMARKS

The Company will be obliged if the Physician will use this space to furnish any additional information not brought out in the foregoing statement.

Form No. GID-117