Death Claim Form

To be completed by Attending Physician

Policy Number | | | | | | | | | |

1. Information of the deceased insured

Name of Insured (Title, First Name, Middle Name, Last Name)

2. Attending physician's statement

To enable us to evaluate the claim for Death Benefit, this section must be accomplished by the Attending Physician providing complete and detailed answers to the following questions:

Association with the Deceased Patient

1. Are you the regular physician of the deceased? ☐ Yes ☐ No
2. Are you the attending physician during the deceased last illness/accident? ☐ Yes ☐ No
3. Are you related to the deceased? If Yes, please state relationship: ☐ Yes ☐ No _____
4. How long have you known the deceased? _____

General Information

1. Details of Death

a. Date of Death (mm/dd/yyyy)	b. Immediate Cause of Death:

2. If death is due to Illness

a. Give complete history of medical condition/illness:
b. Sign/s or symptom/s experience and indications of deceased's failing health:
c. When did the symptom/s and indications of failing health first discovered?
d. How long did the deceased suffered from this condition?

3. If death is due to violent incident:

a. Was death due to accident, suicide or homicide? Please choose among the choices and provide briefly details of the incident:		
b. Was the deceased under the influence of alcohol or drugs at time of the incident? If yes, what cause you to believe so? Please give details.	☐ Yes ☐ No	

4. Provide details of your previous attendance with the deceased for any condition which either directly or indirectly caused the death.

a. Inclusive Dates	b. Complaints and Findings	c. Diagnosis	d. Treatments/Medical Management

5. To the best of your knowledge, does the deceased had any other illness, disease or injury not mentioned ☐ Yes ☐ No
If Yes, please provide details.

a. Nature of illness, disease or injury	b. Inclusive Dates	c. If confined or treated, Name of Clinic/Hospital

3. Attending physician's affirmation

This is to certify that the above statements are true and complete to the best of my knowledge and belief. I allow FWD to collect and store my personal data specified below to process this Claim Form and contact me for any clarification regarding the statements I provided in this Form.

_____
Attending Physician's Signature over Printed Name

_____
Date Signed

_____
Complete Clinic/Hospital Address

_____
Telephone number / Mobile Number

Lic No: _____
PTR No: _____

_____
Field of Specilalization

_____
Email Address

Please do not sign on blank form