

Death Claim Form

To be completed by Attending Physician



Policy Number

Please fill in block letters and tick the appropriate boxes and circles.

1. Information on the Deceased Insured

Title	First Name	Middle Name	Last Name	Ext Name
Age at time of Death		Last Residence Address of the Deceased		

2. Association with the Deceased Insured

a. Are you related to the deceased?	Yes	No
b. Did you personally know the deceased?	Yes	No
c. How long have you known the deceased?	_____	
d. Were you the attending physician during the deceased's last illness or accident?	Yes	No
e. Were you present when the death occurred?	Yes	No
f. Did you personally see the remains of the deceased?	Yes	No

3. Circumstances on the Death of the Deceased Insured (Please provide COMPLETE and detailed answers to the following questions)

1. Provide details of death

Date of Death (mm/dd/yyyy)	___/___/_____	Place of Death	
Immediate Cause of Death			

2. If death is due to medical condition or natural cause, please provide details: (Please use extra sheet of paper if needed)

Give complete history of medical condition/illness including the dates it was experienced	
Sign/s or Symptom/s Experienced	
Date symptoms first discovered	
How long did the deceased suffered from the condition	

3. If death is due to violent incident, please provide details: (Please use extra sheet of paper if needed)

State the nature of the violent incident			
Details of the accident	Date (mm/dd/yyyy)	Time of Accident	Place of Accident
	___/___/_____	___:___ AM PM	
Narrate completely how the accident happened			

3.1. Was the patient under the influence of alcohol, improper use of drugs or narcotics at time of accident? Yes No
 If Yes, what cause you to believe so? Please give details.

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4. What were the first indications of the deceased's failing health?

Date it was first noticed by the deceased	

5. Please provide date when you were first consulted for the condition which either directly or indirectly caused the death?

Date of your first attendance with the deceased	
What was the chief complaint of the deceased	
What was your diagnosis then and treatments given to the deceased	

POLICY NUMBER: _____

6. Who referred the deceased to you? Please indicate his/her full name and address.

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7. Have you previously attended the deceased during his/her last illness? Yes No

Please give particulars of any illness or investigations for which the deceased has consulted with you:

Complaints and Findings	Diagnosis	Date Attended	Treatment or Medical Management

8. Did the deceased suffer from any other illness, disease or injury before death that were not mentioned above?
If Yes, please provide details. Yes No

Nature of illness, disease or injury	Inclusive dates of illness	If confined or treated, Name of Clinic/Hospital

9. Please answer the following questions.

Question	YES	NO	Please provide details to the "YES" answer
a. Did the deceased have any family history of medical illnesses which may have led to or contributed to the cause of the death?	<input type="radio"/>	<input type="radio"/>	
b. Was the death due to suicide / homicide / accident?	<input type="radio"/>	<input type="radio"/>	
c. Did the deceased smoke cigarettes/cigars or consume any other tobacco products or prohibited drugs?	<input type="radio"/>	<input type="radio"/>	
d. FOR FEMALE ONLY: Was the death related with or a complication of pregnancy?	<input type="radio"/>	<input type="radio"/>	

10. Was the deceased ever confined in a hospital or other institution for any condition or injury?
Please provide details. Yes No

Name of Hospital / Clinics / Other Institution	Inclusive Dates	Reason of confinement

11. Name other physicians who attended to the deceased for any illness / disease or injury.
Please provide details.

Name and address of Physician/s	Inclusive Dates	Diagnosis / Treatment given

12. Was there an autopsy or other post mortem examination made on the body of the deceased?
If yes, please give a copy of the report and provide details below: Yes No

Date of Autopsy	Place of Autopsy	
Result		

13. Do you consent FWD to release the information you provided in this report to the deceased's family and/or claimants when requested to explain our decision? Yes No

4. Affirmation Section

Place of signing _____ Date:

m	m	/	d	d	/	y	y	y	y
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Attending Physician's Signature
over Printed Name

Complete Clinic/Hospital Address

Telephone number / Mobile Number

Lic No: _____
PTR No: _____

Field of Specialization

Email Address

5. Data Protection

FWD has appointed a Data Protection Officer to handle any inquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Corporation Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 19/F, W Fifth Avenue Bldg., 5th Avenue cor. 32nd Street, Bonifacio Global City, Taguig City 1634, Philippines.

PLEASE DO NOT SIGN ON A BLANK FORM.