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 occured? ○ 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.

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.

7. Have you previoulsy 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?	○	○	
b. Was the death due to suicide / homicide / accident?	○	○	
c. Did the deceased smoke cigarettes/cigars or consume any other tobacco products or prohibited drugs?	○	○	
d. FOR FEMALE ONLY: Was the death related with or a complication of pregnancy?	○	○	

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

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? ○ Yes ○ No
If yes, please give a copy of the report and provide details below:

Date of Autopsy		Place of Autopsy	
Result			

13. Do you consent FWD to relase 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

_____ Attending Physician's Signature over Printed Name

_____ Complete Clinic/Hospital Address

_____ Telephone number / Mobile Number

Lic No: _____
PTR No: _____

_____ Field of Specilalization

_____ 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.