

**ATTENDING PHYSICIAN'S STATEMENT
MADE TO ASIANLIFE & GENERAL ASSURANCE**

(Before making out this statement, please read instructions at the back.)

1. Deceased's full name and residence at death	Name Residence
2. Deceased's age, sex and occupation at death.	Age Sex Occupation
3. From physical findings and appearances, what would you judge to be the age of the deceased?	
4. How long have you known the deceased?	
5. a. Did you personally see the remains of deceased? b. Any identifying marks in the body, i.e. moles, scars, etc.? Specify.	a. YES NO b.
6. Deceased's date and place of death. (if in any Institution or hospital, give name)	Date Place
7. Cause/s of Death	
8. How long did deceased suffer from this injury or illness? Please give basis for your answer.	
9. In last illness/injury causing death, give the date of the first and last attendance.	Date of first attendance Date of last attendance
10. Date deceased was confined to house and prevented from attending to business and bedridden.	Date confined to house Date prevented from attending to business Date bedridden
11. Your diagnosis of deceased's condition. (Describe briefly treatment given.)	
12. Did you inform deceased of your diagnosis? If so, when?	
13. Was death due to suicide, homicide or accident? (Specify which and describe briefly)	
14. a. Was an autopsy performed? b. If so, by whom and with what findings?	a. <input type="checkbox"/> YES <input type="checkbox"/> NO b.
15. a. Have you treated or advised the deceased during the last 3 years prior to last illness? b. Did the deceased receive treatment during the past 3 years from any other physician, hospital or institution?	a. <input type="checkbox"/> YES <input type="checkbox"/> NO b. <input type="checkbox"/> YES <input type="checkbox"/> NO

IF ANSWER TO EITHER QUESTION 15 a & b IS YES, PLEASE FURNISH US THE FOLLOWING:

Name of Physician/ Hospital	Address	Nature of Illness/ Injury	Dates From	To

These statements are true and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____, 20 ____.

Signature of witness

Printed Name

Address

SIGNATURE OF PHYSICIAN

PRINTED NAME

ADDRESS

INSTRUCTIONS

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

In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering question # 7.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, give type part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seemed desirable should be given below.