ASIANLIFE
& GENERAL ASSURANCE CORPORATION

3rd Flr. Morning Star Center,
347 Sen Gil Puyat Avenue, Makati City
Tel. No. 890-1758* Fax No. 895-8524

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 AsianLife & General Assurance Corporation
I, __________________________, a graduate of ______________________________________
in the year _________________, with residence address at _____________________________________,
hereby truthfully and voluntarily state as follows

1. (a) Full Name of Deceased
____

(b) Residence at time of death
____

(c) From physical findings and appearances what would you judge to be the age of the deceased?__________________

(d) What identifying marks have you noticed in the body of the deceased?____________________
____

2. (a) Do you know deceased personally?
____

(b) How long have you known the deceased?
____

(c) How many times did you attend to deceased?______________________

(d) When was your first attendance?
____

(e) What were deceased's complaints in your first attendance?_____________
____

(f) Who called you or accompanied the deceased for treatment?___________________________
____

(g) Did you informed deceased of your diagnosis?____

3. (a) Did you attend to deceased during last illness?_______________________

(b) If so, for what disease?____________________
____

(c) What disease was the immediate cause of death?__________________
____

(d) How long did deceased suffer from this disease?(give details)_______________________
____

(e) What were the first indications of failing health?____________________
____

(f) For how long before death was deceased confined to house or prevented from attending to business?____________________________

(g) Give date and hour when they were noticed by deceased.______________

(h) For how long was deceased bedridden?
____

4. (a) From what other disease, if any did deceased suffer?_________________
____

(b) Give as nearly as you can the duration of each.
____
____

(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?____

*** see back page ***

ATTENDING PHYSICIAN'S STATEMENT

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	Licensed 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 accomplished 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 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