PACIFIC CROSS VIETNAM

The strength behind your insurance

ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIM

Please print in BLOCK Letters

(to be completed by the deceased's last attending physician without expenses to insurance company)

Name of Policyholder: _____ Policy No.: _____

Name of Deceased: _____ Member No.: _____

Sex: ____ Age: ____ Date of Birth (day/month/year): _____ Passport/ I.D.No.: _____

Residence at the time of death: _____

Occupation prior to death: _____

1. a. Were you the last attending physician of the deceased? If not, please give details of the last attending physician?

_____

_____

b. Date on which you first saw the deceased?

_____

_____

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

_____

_____

d. How long have you acquainted with the deceased?

_____

_____

e. Please give particulars of any illnesses or investigations for which he/ she has consulted you:

Date Attended (day/month/year)	Complaints & Abnormal Physical Findings	Duration of Illness	Diagnosis	Describe Treatment (including name of drugs prescribed) or Operation

2. a. Date of death: _____

b. Place of death: _____

c. Cause of death: _____

3. To the best of your knowledge, please give names and address of all other physicians who attended the deceased during the past three years.

Date (day/month/year)	Disease/ Disorder	Details of Treatment/Hospitalization	Name and address of the physicians

4. Was there any medical condition in any way contributed or predisposed to the cause of death? If "yes", please provide details.

_____

_____

5. a. Did the deceased have any habit of smoking, alcohol drinking or taking drugs? Yes ❑ No ❑

b. Did the deceased suffer any illness which predispose to cause the death, in the past? Yes ❑ No ❑

c. Did the deceased have any family history which predispose to cause the death? Yes ❑ No ❑

d. Was the death related to self-inflicted behavior? Yes ❑ No ❑

For Females Only:

e. Was the death related to pregnancy or complication of pregnancy? Yes ❑ No ❑

For any "yes" answer, please state the question number and give details

_____

_____

6. Was there any post-mortem examination done in the deceased's body? Yes ❑ No ❑

If "yes", please give a copy of the report

7. Do you consent insurance company and/or claim assessor to release the information provided by you in this report to the deceased's family and/or claimant(s) when we are requested by the deceased's family and/or claimant(s), to explain our claim decision Yes ❑ No ❑

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.

Name of Attending Physician: _____ Signature (with stamp): _____

Qualification: _____ Date (day/month/year): _____

Tel: _____

Fax: _____

Email: _____