



The Insular Life Assurance Company, Ltd.
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Tel.: (632) 8-582-1818 | VAT REG. TIN 000-464-124-000

*Before accomplishing this form, physician will
read instructions at the back.*

Attending Physician's Statement

In proof of my medical attendance to _____ submitted to The Insular Life Assurance Co., Ltd, at the instance of the claimant/s on Policy No./s _____.

I, _____ a graduate of _____
(Name of Physician) (Name of Medical School)

in the year _____ with residence at _____

hereby truthfully and voluntarily state as follows:

1. a. Full name of deceased:	4. a. Did you attend to deceased during last illness?
b. Last residence of deceased:	b. If so, for what disease?
c. From physical findings and appearance, what would you judge to be the age of deceased?	c. What disease was the immediate cause of death?
d. What identifying marks have you noticed in the body of deceased, say a mole or scar or any part of the body?	d. How long did deceased suffer from this disease? (Please give basis for your answer.)
2. a. Do you know deceased personally?	e. What were the first indications of failing health?
b. How long have you known deceased?	f. Give date and hour when they were first noticed by deceased.
c. How many times did you attend to deceased?	g. For how long before death was deceased confined to house or prevented from attending to business?
d. When was your first attendance and what were deceased complaints?	h. For how long was deceased bed-ridden?
e. Who called you or accompanied the deceased for treatment?	5. a. From what other disease, if any, did deceased suffer?
f. What was your diagnosis then and what treatments did you give to deceased?	b. Give, as nearly as you can, the duration of each.
g. Please state previous attendances Date _____ Disease/Illness _____	c. Other physicians who attended to deceased for any illness: (Please give also, their addresses.)
h. Did you inform deceased of your diagnosis?	d. Other hospitals or Institutions where deceased was confined for any cause: (Please state location.)
3. a. Was deceased ever confined in a hospital or other institution for treatments of any disease or injury?	6. a. Did you personally see the remains of the deceased?
b. If so, state which hospital or institution, for what disease injury and give exclusive dates of confinement.	b. Date and place of death:
	c. Was there an autopsy or other post-mortem examination made on the body of deceased?
	7. Would you swear to the truth of the foregoing?

Done at _____ on _____

Name and signature of Witness

Physician's Signature

PTR License No.

Date Issued

SUBSCRIBED AND SWORN to before me Dr. _____, who exhibited to me his/her Govt. issued ID/Passport No. _____ issued at _____, on _____.

Doc. No. _____
Page No. _____
Book No. _____
Series of 20 _____

Notary Public
My commission expires on _____

INSTRUCTIONS

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. It must be notarized.

If more than one physician attended to the deceased, the statement of each must be accomplished in separate forms, 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, in answer to pertinent questions, a full statement of each pathological process, especially as to its duration.

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 submitted along with this Attending Physician's Statement.

Where the spaces provided for the answers are too small, such desirable details may be given on this page, 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.)