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ATTENDING PHYSICIAN'S STATEMENT – ACCIDENTAL DEATH & DISABILITY CLAIM

Note: Kindly submit this form to Generali Life Assurance Philippines, Inc., (GLAPI) duly completed by a qualified and registered physician at the expense of the claimant.

PATIENT'S DETAILS

Last Name	First Name	Middle Name
Address		

Date of Birth (MM/DD/YYYY)	Place of Birth	Age	Status
Date of Death	Place of Death		

How long have you known the patient?

When did the patient first consult you for the injury?

What was the cause of the patient's injury? Please describe in detail.

What is your final diagnosis

If Surgical Procedure was performed, please describe in detail and provide copy of the Operation Room Record.

Please classifify his disability: ☐ Total Permanent ☐ Partial Permanent ☐ Total Temporary ☐ Partial Temporary

If partially disabled, what is the degree of incapacity?

☐ IF CLAIM IS DUE TO DISABILITY BENEFIT

Is the patient able to perform any and every duty of his own occupation? ☐ Yes ☐ No

If yes, when is he/she expected to return to his/her usual occupation?

If no, when did he/she cease all work.

☐ Yes ☐ No

In your opinion, is the patient totally and permanently disabled and unable to engage in any occupation or perform any work for income or profit currently or at anytime thereafter.

☐ IF CLAIM IS DUE TO DEATH BENEFIT

Cause of Death
Immediate Cause

Antecedent Case

Underlying Cause

Other significant factors contributing to death

PLEASE GIVE DETAILS OF THE PATIENT'S PREVIOUS CONDITIONS FOR WHICH YOU ATTENDED PRIOR TO LAST ILLNESS/INJURY:

Date of Attendance	Diagnosis	Treatment/Procedure

Did you personally see the remains of the deceased? ☐ Yes ☐ No
Was there an autopsy or any other post-mortem examination made on the body of the deceased? ☐ Yes ☐ No

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I HEREBY CERTIFY that the above statements are true and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ 20 _____.

_____ _____

SIGNATURE OVER PRINTED NAME OF PHYSICIAN | QUALIFICATION

_____ _____

ADDRESS | CONTACT DETAILS

SUBSCRIBED AND SWORN to me this _____ day of _____,20 _____ by the aboce claimant who exhibited to me his/her Residence Certificate No. _____ issued at _____ on _____.

Doc. No. _____ Book No. _____

Page No. _____ Series of _____

My Commission expires on _____

_____

NOTARY PUBLIC