Paramount Life & General Insurance Corporation

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Madaling Kausap.

PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION
ATTENDING PHYSICIAN'S STATEMENT

1. Deceased's full name and residence at death	Name Residence
2. Deceased's age, sex and occupation at death	Age Sex Occupation
3. How long have you known the deceased?	
4. 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.
5. Deceased's date and place of death. (If any, institution or hospital, give name).	Date Place
6. Cause of death	
7. How long did deceased suffer from this injury or illness? Do you know if deceased had other serious illness or impairement? Please give date, basis, name of information for your answer.	Date Informant's Name
8. In last illness/injury causing death, give the date of the first and last attendance.	Date of first attendance Date of last attendance
9. Date deceased was confined to house and prevented from attending to his business or occupation.	
10. Your diagnosis of deceased's condition. (Describe briefly treatment given).	
11. Did you inform deceased of your diagnosis? If so, when?	
12. Was death due to suicide, homicide or accident? (Specify which and describe briefly).	
13. a. Was autopsy performed? b. If so, by whom and what were the findings?	a. ☐ Yes ☐ No b.
14. a. Have you treated or advised the deceased during the last 3 years prior to last illness? b. Did the deceased receive the treatment during the past 3 years from any other physician, hospital or institution?	a. ☐ Yes ☐ No b. ☐ Yes ☐ No

15. If answer to either question 14a or 14b is yes, please furnish us the following:

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

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

Dated at ____________________________ this ______________ day of __________________________ 20_____.

______________________________ Physician's Full Name

______________________________ Physician's Signature

______________________________ Physician's Address

______________________________ License No./ Expiry Date