ATTENDING PHYSICIAN's STATEMENT for Death Claims

To. Our Colleague – Attending Physician,
We really appreciate your kind support to fill in the following form in accordance of the data and the facts. Please include medical documentation to support your statement.

PT AXA Financial Indonesia

Personal Details of the Late Insured

Name of the Late Insured : _____
Date of Birth / Age : _____ / ____ y.o
Address : _____

Medical Record. No. : _____
Gender : ☐ Male ☐ Female

Cause of Death Condition(s) which causing the Death Place Date & Time of Death	☐ Illness / Diseases ☐ Accident ☐ Others : _____ _____ ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) Time: _____
Death due to Illness or Diseases Primary cause of Death Diagnose When was the symptoms initially indicated?	_____ _____ ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
Death due to Accident Please briefly describe cause of death Were the incident happen in relation with the consumption of alcohol / narcotics / drugs?	_____ _____
Death cause by others Please briefly describe cause of death	_____
Were you presence in the event of Death? **If YES** Any health problems or symptoms share prior to the late's death? **If NO** When were the last medical consultation to the late's death?	☐ Yes ☐ No _____ _____ ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
Medical Records When was the first consultation arranged? What was the symptom(s) shared during the first consultation? What was the diagnosis? Was the symptom(s) has any correlations to Hypertension, Diabetics, Cardiac arrest, Lungs, Psychiatric, Congenital, Narcotics, HIV, and any other disease? (please advise) Were there any relationship for the cause of death with any symptom(s) stated above? Kindly advise for any other Physician / Doctor(s) and address where the Late's visit prior / during the consultation	☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) _____ ☐ Yes ☐ No Diagnosis: _____ Suffered since: _____ ☐ Yes ☐ No If Yes, briefly described _____ _____

I certify that all information and data provided is based on my opinion of his/her condition. I declare and agree to make the declaration on this Attending Physician's Statement Form

Name : _____
Hospital : _____
Place : _____
Date : _____

Medical Specialty : _____
Phone No. / Cell Phone : _____

Doctor' Signature **Hospital's Stamp**

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