



CLIMBS LIFE AND GENERAL INSURANCE COOPERATIVE

Home Office: CLIMBS Bldg., Zone 5, National Highway, Bulua, 9000 Cagayan de Oro City, Philippines

Tel. Nos.: (08822) 738738; (088) 8561355 /Fax Nos.: (08822) 738722; 738886 *** Website: www.climbs.coop

Email: head_office@climbs.coop, metro_manila@climbs.coop, metro_cebu@climbs.coop, metro_davao@climbs.coop

ATTENDING PHYSICIAN'S STATEMENT

In proof of _____ submitted to the **CLIMBS LIFE AND GENERAL INSURANCE COOPERATIVE** at the claimant Policy No. _____.

PHYSICIAN WILL PLEASE READ IMPORTANT NOTICE ON BACK OF THIS SHEET

This Statement must be made by the Physician in attendance during the last illness of the deceased, and must be entirely in his own handwriting. If more than one physician was employed, the statement of each must be furnished upon separate forms, which will be sent if required.

When an autopsy has been made by order of the court, a copy of the verdict and of the evidence upon which it was based duly certified must be furnished.

-
1. Name of the deceased in full _____
 2. Residence _____
 3. Last Occupation of the deceased _____
 4. How long did you attend the deceased? _____
 5. Did you attend or were you consulted by the deceased before the last illness? If so, when and for what illness, giving details including dates. _____
 6. A. Did you attend the deceased during his last illness? _____
B. If so, for what disease? _____
 7. A. Date and hour of your first visit _____
B. Date and hour of your last visit _____
 8. A. Did any other physician attend the deceased during last illness? _____
B. Give name and address of each date of his first visit and the duration of his attendance _____
 9. A. Place of death _____
B. Date of death _____
 10. A. What disease was the immediate cause of death? _____
B. How long in your opinion, did the deceased suffer from this disease? _____
 11. A. What were the first indications of failing health? _____
B. When were they first noticed? Give date and hour if possible _____
 12. A. From what other disease, if any, did the deceased suffer? _____
B. Give as nearly as you can, the duration of each one _____
 13. Did previous illness, family history or habits in any way predispose the deceased to the cause of death? If so, describe fully. _____
 14. For how long before death occurred was the deceased confined to the house or prevented from attending to business? _____
 15. From physical findings and appearances, what would you judge to be the age of the deceased? _____
-

16. A. Was death caused, directly or indirectly, by the habits, occupation?

B. Does the deceased use alcoholic beverage of any kind? If so, to what extent or effect?

17. A. Where did you receive your medical education?

B. When and where did you graduate?

18. A. Was there an autopsy or a post-mortem examination in the body of the deceased?

B. If so, state which, by whom and give the result.

19. Did you personally see the remains of the deceased?

20. Do you guarantee that all the statements and answers made by you in this questionnaire are true and that you have not concealed any material fact from the Company?

Having been duly sworn, I hereby depose and say that the statement in the foregoing answers are true and full, to the best of my knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at _____ this _____ day of _____, 20____.

Witness

Attending Physician

Address

Address

On this day of _____, 20____, personally appeared before me the above named sworn, and subscribed the same in my presence affiant exhibited to me his Residence Cert. No. _____ issued on _____, 20____.

Doc. No. _____ Book No. _____ Series of _____ .

THIS STATEMENT SHOULD BE SWORN TO BEFORE A NOTARY PUBLIC OR OTHER DULY AUTHORIZED TO ADMINISTER OATHS WITH HIS OFFICIAL SEAL ATTACHED. IF HE HAS NO SEAL, HIS AUTHORITY AND GENUINNESS OF HIS SIGNATURE MUST BE ATTESTED BY A JUSTICE OF THE PEACE OR BY A CLERK OF COURT OR RECORD.

IMPORTANT NOTICE

The Physician who filled up this blank form will facilitate the PROMPT PAYMENT of THE CLAIM by giving answers to Questions No. 10, 11, 12, 13, 14 and 16, a full statement of each. Pathological process especially as to its duration and results.

Such indefinite as Heart Failure, Exhaustion and the like, are to be avoided unless full details are added.

Where death is the result of Accident or Injury, the word LESION may be understood to replace DISEASE in question 10.

Where the spaces set apart for the answers are too small, desired details may be written below this page, under ADDITIONAL REMARKS.

ADDITIONAL REMARKS: