



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?

Yes No

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?

_____/____/____ (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

Customer Care Centre

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