PARAMOUNT
LIFE & GENERAL
INSURANCE

14th Floor, Sage House, 110 V.A. Rufino St.,
Legaspi Village, Makati City, 1229 Philippines
Tel. No.: +(632) 8772 9200
Fax No.: +(632) 8772 9297
www.paramount.com.ph

ATTENDING PHYSICIAN'S STATEMENT
FOR DEATH CLAIMS

Name of Deceased:	
Residence at Death:	
Apparent Age at Death:	
Date of Death :	
Place of Death:	

1. What was the immediate cause of death?

2. What factors/disease contributed to the cause of death?

Duration of contributory causes?

3. What was the first indication of failing health?

When they were first noticed?

4. Were there any other disease/s suffered by the deceased?

If yes, kindly mark them from the choices below and indicate when were they diagnosed? If they are not found from the selection, you may place them, on the space provided.

	Date / Year Diagnosed
☐ Hypertension	______________
☐ Diabetes Mellitus	______________
☐ Heart Disease	______________
☐ Kidney Disease	______________
☐ Others	______________

Would you know if the deceased suffered from any congenital disease/s? ☐ Yes ☐ No

If yes, kindly specify?

5. Was the deceased bedridden prior to his/her demise? ☐ Yes ☐ No

If Yes, since when?

If No, was the deceased prevented from attending to his daily work activities prior to his demise? ☐ Yes ☐ No

6. When did you first attended the patients?

Date of FIRST attendance in last illness?

Date of LAST attendance in last illness?

7. Was there any evidence that would indicate that the deceased died of suicide or foul play such as murder?

☐ Yes ☐ No If yes, kindly specify?

8. Did you personally see the remains of the deceased? ☐ Yes ☐ No

If not, who did?

Complete Name, Address and Contact Number of the Informant:

9. Was there any autopsy done? If yes, state which, by whom and what were the findings?

I hereby certify to the best of my knowledge that the above statements are true and correct.

____

SIGNATURE OVER PRINTED NAME

Full Name of Attending Physician:			
License No.:		**Signature**:	
Clinic Address and Contact Numbers/s:			
Full Name of Attending Physician:			

FRAUD WARNING

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

DATA PRIVACY CONSENT STATEMENTS

I hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, customer/client profiling, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), its subsidiaries, affiliates, directors, officers, employees, and agents (a) to verify and/or confirm any or all the information provided or representation made, (b) to provide, facilitate, monitor, improve the quality of, or otherwise service my account and such products, services, and facilities and/or channels availed by me or may be offered by PLGIC, and (c) to comply with legal, regulatory or other obligations of PLGIC under applicable local or foreign laws, rules and regulations.

I likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, and customer/client profiling, by authorized third parties for the foregoing purposes.

Such processing may be conducted for the duration of my availment of PLGIC's products, services, facilities and/or channels. I further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties, of my personal data which may be inaccurate or incorrect.

I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided. I understand and agree that the consent hereby given may be revoked or withdrawn though formal written notice to PLGIC.

Finally, I authorize PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties to obtain such other information they may deem necessary to verify or confirm the personal data declared or the documents furnished in relation to this application, and that I agree that such documents may remain in the possession of PLGIC whether or not this application is granted, for the purposes above mentioned.

Signed at ____ this ________ day of ______________ ,20 ______

____________________________________ ____________________________________

Signature Over Printed Name of Witness | Signature Over Printed Name of Claimant Beneficiary