East West Ageas Life Insurance Corporation
15th Floor, One World Place, 32nd Street, Bonifacio Global City, 1634 Taguig City, Philippines
Tel: +63 2 8683 8766 TIN: 009 156 012 000

Death Claim

Attending Physician's Statement

IMPORTANT: The attending Physician must fill out this form by hand. If there was more than one doctor, then each doctor must accomplish a separate form. The form/s must be sent to Troo, if deemed necessary.

Full name of Deceased

Last name	First name	Middle name

Residence of Deceased

Occupation of Deceased at death

How long have you known the Deceased?

How long did you attend to the Deceased?

Have you been attending to or were you consulted by the Deceased before the last illness/injury?
If yes, *please provide dates and information on the illness/injury.*

What is the immediate cause of death?

When were you first consulted for the illness/injury (directly or indirectly)?

a. When was the last date of visit?

b. Who consulted you? (Please specify if deceased, relatives or others)

How long did the Deceased suffer from illness/injury? Please provide details for your answer.

What are the contributory causes of death? (Please provide details of each.)

Disease/injury	Duration

Please give the names of other physicians/practitioners who, to your knowledge, attended to the Deceased during the last illness/injury.

Name of physician/hospital/institution	Disease/injury: dates attended

Was there any special connection (remote or proximate) between the death and personal history, habits, occupation or residence of the Deceased? If yes, *please state which and give particulars.*

Was the death due to accident, homicide or suicide? If yes, *please provide details.*

Was the Deceased under the influence of liquor or prohibited drugs when the accident/homicide/suicide happened? If yes, *please provide details.*

Was there an official inquiry as to the cause of death or a post-mortem examination on the body of the Deceased? If yes, *please provide details.*

DECLARATION:
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION:
I further authorize the Medical Director or any of his/her authorized representatives to furnish Troo or its authorized representatives all medical records of the Deceased/patient.

A photographic copy of this authorization is valid as the original.

Signature over Printed Name of the Attending Physician

Date
M M D D Y Y Y Y

Specialization	
License no	
Contact numbers	
Email address	
Clinic address	
Clinic hours	

Certificate of Claimant's Authorization

This is to authorize Troo and/or its duly authorized representatives to secure whatever information or records you may have, regarding the illness/sickness/injury, or such other records relative to claim/s filed under the policy/ies issued by said company on the insured/deceased _____

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such records or information. A photographic copy of this authorization is valid as the original.

_____
Date and Place of Signing

_____
Signature over Printed Name of Claimant/s