ST. PETER
LIFE PLAN • CHAPELS

NOTE: Please write legibly. The Company reserves the right to require further information if necessary as noted in the signed authorization / contract of the Planholder.

TYPE OF CLAIM:

☐ CASH ASSISTANCE / EXTENDED CASH ASSISTANCE BENEFIT
☐ WAIVER OF INSTALLMENT (Total and Permanent Disability)
☐ ACCIDENTAL DEATH BENEFIT
☐ ACCIDENTAL DISMEMBERMENT BENEFIT

ATTENDING PHYSICIAN'S STATEMENT

In proof of the death / disability / dismemberment of _____submitted to ST. PETER LIFE PLAN, INC. (herein called the Corporation), at the instance of the claimants under Policy No. _____.

For the Physician : PLEASE READ IMPORTANT NOTICE AT THE BACK.

This statement shall be made by the attending physician during the last illness of the patient (planholder). If more than one physician attended the planholder (patient), the statement of each must be furnished in 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 avoidance upon which it was based, duly certified, must be furnished.

1. Name of patient (planholder) in Full	
2. Residence Address	
3. Last occupation of patient (planholder)	
4. How long did you attend to the patient (planholder)?	
5. Did you attend or were you consulted by the patient (planholder) before the last illness? If so, when and for what illness? Please give details including dates of onset & its duration.	
6. a. Did you attend to the patient (planholder) during his last illness?	a.
b. If so, for what disease?	b.
7. a. Date of your first visit	a.
b. Date of your last visit.	b.
8.. a. What disease was the immediate cause of death / disability?	a.
b. How long, in your opinion, did the patient (planholder) suffer from the disease?	b.
9. A. If deceased : a. Place of death	a.
b. Date of death	b.
B. If totally and permanently disable : a. Date of diagnosis of total and permanent disability	a.
10. a. What were the first indications of failing health?	a.
b. When were they first noticed? Please give details..	b.
11.a. From what other disease, if any, did the patient (planholder) suffer?	a.
b. Give the dates attended / duration of each medical condition.	b.
	c.
12. If due to accident, which body part was affected or dismembered? Please provide details and extent of dismemberment.	
13. Did previous illness, family history or habits in any way predispose	a.
the patient (planholder) to the cause of death / disability? If so, describe fully.	b.
14. For how long was the patient (planholder) confined in the house, or prevented from attending to business before his / her death / disability?	
15. a. Is the patient capable of performing the activities of daily living (ex. washing, dressing, transferring, mobility, toileting,feeding, etc.)?	a.
b. If no, please provide details and duration of the activities the patient was not able to perform.	b.
16. a. Was death / disability caused directly or indirectly by the habits, occupation and/or living conditions of the deceased?	a.
b. Did the patient (planholder) use alcoholic beverages or under the influence of drugs prior to the incident?	b.
c. If yes, to what extent and effect?	c.
17. a. If deceased, was there an autopsy or a post mortem examination on the body of the patient (planholder)?	a
b. If so, state which, by whom and give the result.	b.
18. Did you personally see the patient (planholder)?	
19. 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 Corporation?	

Having been duly sworn, I hereby depose and say that the statements I have written here are true and complete to the best of my knowledge and belief, and that there are no material facts of the case which are not disclosed.

Accomplished at _____, this _____ day of _____, 20___.

_____ _____

Witness Attending Physician / PRC License Number

_____ _____

Address Clinic Address / Mobile Number

On this _____ day of _____, 20____, personally appeared before me the name indicated above, know as a physician in regular standing, who has duly sworn, deposed that the answers to the above questions are full and true to the best of his knowledge, information and belief and subscribed the same in my presence. Affiant exhibited to me his/her Residence Certificate No. _____issued at _____on _____, 20___.

IMPORTANT NOTICE

The physician who filled out this form will facilitate the prompt payment of the claim by giving in answer to Questions No. 10, 11, 12, 13, 14 & 15, a full statement of each pathological process especially its duration and results. Such indefinite terms 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 No. 10. If the answers are too long for the spaces provided, such details may be recorded under ADDITIONAL REMARKS.

ADDITIONAL REMARKS

NOTE: The Corporation will be much obliged to the Physician, if he will use this space to furnish any additional information not brought out in the foregoing statement.