Attending Physician Statement - Individual Claim for Death Benefit

(To be filled by the attending physician)

Patient's Name: P/W

Information of Insured

To: The Attending Physician
Dear Sir/Madam,
Kindly your assistance to fill all the questions below completely and correctly to the extent of your knowled

im for Death Benefit insurance			
ectly to the extent of your knowledge of the patient.			
Patient's Medical Record No. :			
Patient's Address :			
Time :			
death in home			
Others, please explain:			
since:			
Hospital:			
1 copical			
rgery:			
es, please explain:			

Date of Birth :, Age:, Age:		
Death Information		
Date & Time of Death Place of Death	Please describe the chronology if death in home	
Cause of Death Diagnosis	Accident Disease Others, please explain:	
If Caused by Disease		
When did the symptoms the Insured prior to the first consulation? The physician name who referred the Medical Examination Result (Laboratory, Radiology, MRI, CT scan, Angiography, Pathology Anatomy, USG, .etc Was a Surgery performed?	patient: Hospital: Hospital: No Yes, type of surgery:	
If Cause by Accident		
Chronology of Accident :	e by: No Yes, please explain: No Yes, please explain:	
Medical History		
Hypertension, DM, Heart Disease, Lung HIV, etc? Diagnosis:::::::::::::::::::::::::::::::::::		
Date :	(Doctor's Signature & Hospital Stamp)	

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Bebaskan langkah fwd.co.id