PIONEER®
YOUR INSURANCE

CERTIFICATE OF ATTENDING PHYSICIAN

All questions must be answered in full.
The Company makes no admission of liability or waiver of rights by furnishing this form.

1. Full Name	
2. Residence at time of death	
3. (a) Date of Death	(b) Place of Death
(c) Age at Death	(d) Occupation at the date of death
4. How long have you known the deceased?	
5. Length of hospitalization	
6. (a) When were you first consulted for the condition which either directly or indirectly caused death?	
(b) Who consulted you? (Specify if deceased, relative or others)	
(c) Date of last visit	
(d) What was the cause of death? (Immediate, proximate, underlying)	
(e) In your opinion, how long did the deceased suffer from this disease or impairment?	

(f) What were the contributory causes of death? State the duration of each:

Disease or Impairment	Duration

(g) Was there any connection (remote or proximate) between the death and occupation, residence, habits or personal history of the deceased? Yes ☐ No ☐ If "yes", state which and give particulars.

7. State particulars of each condition for which you treated or advised deceased prior to last illness:

Nature of Condition	Dates	Duration	Result of Treatment

8. State names and addresses of other physicians and other practitioners who, to your knowledge, attended to the deceased during the past three years:

Name	Address	Disease or Impairment	Date

9. (a) Was the death due to suicide or accident? Yes ☐ No ☐

(b) Was the deceased under the influence of liquor or drugs when accident/suicide happened? Yes ☐ No ☐

10. Was there any official inquiry as to cause of death or a post mortem examination on the body of the deceased?
Yes ☐ No ☐ If "yes", by whom and with what result?

Date	Physician's Name	Physician's signature

License No.: _____ Telephone No.: _____

MEDICAL INFORMATION AUTHORIZATION

To: Medical Records Section, Hospital/Clinic: _____

This is to authorize the representative of Pioneer Life Inc. to examine the chart/record of my patient, _____ who was confined on _____ to _____ and photocopy the complete hospital record/s for evaluation of the patient's insurance claim.

Date: _____ Physician's Signature: _____
Signature over Printed Name

PIONEER LIFE INC.
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PART B ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name: Date of Birth: Age:

2. a. Diagnosis and Concurrent Conditions:

   b. Date the condition was diagnosed: _____

   c. If confined: From _____ To _____ Where _____

3. Complete Admitting History (For Present Illness, include the date the symptoms first appeared or accident happened, and date patient first consulted for illness/injury):

4. Past Medical History:

5. Pertinent Physical Examination Findings:

6. Significant Diagnostic Procedure Findings:

7. Treatment

Date of treatment rendered	Place of treatment	Description of Medical Surgical/ Rehab treatment

8. Is the injury or sickness work-related? Yes ☐ No ☐

9. Did the Patient have a recurrence or similar condition before? Yes ☐ No ☐ If "yes", when? Please give details.

10. Is the Patient still under your care for this condition? Yes ☐ No ☐

11. Will this injury likely restrict him from engaging in any gainful occupation? Yes ☐ No ☐

    To what extent? ☐ Partial ☐ Total ☐ Temporary ☐ Permanent

12. Duration of above disability: From: _____ To: _____

_____

Date Physician's Name (Print) Signature License No.

Address _____ Tel. No. _____

AUTHORIZATION

To: Medical Records Section / Hospital / Clinic _____

I hereby authorize you to disclose when requested to do so by PIONEER LIFE INC., or its representative, any and all information, with respect to above condition, including medical history, consultation, prescriptions or treatment, and copies of all hospitals or medical records. A photocopy of this authorization shall be considered as effective and valid as the ORIGINAL.

NOTE: 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.

I / We hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I / We understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the Policy shall be void and all the rights to recover thereunder in respect of past or future claims shall be forfeited.

_____ _____

Physician's Signature over Printed Name Date

FAILURE TO COMPLETE THIS FORM MAY DELAY PROCESSING/PAYMENT OF YOUR CLAIM.