

15th Floor Ayala Life - FGU Center, 6811, Ayala Avenue, Makati City 1226

## Attending Physician's Statement Critical Illness / Dismemberment Claim Form

NOTE: Fill out 🗌 with block letters.

Put 🚺 on the tick boxes representing options.

Please use reverse side for answers requiring additional information but not indicated on this questionnaire. Identify your answers with the corresponding numbers.

### **PATIENT'S INFORMATION**

Name:				
Last Name	First Name	Middle Name		
Date of Birth:	Are you related t	o the patient? Ses No		
	If yes, please sta			
mm / dd / yyyy				
Gender: Male Female				
PHYSICIAN'S STATEMENT (To be filled	up only by a licensed Physician)			
<ol> <li>Name the Critical illness/Dismembermer (please refer to insured's policy contract if</li> <li>Cancer of the</li> <li>Cerebrovascular Stroke</li> <li>Coronary Artery Disease/ Bypass Surger</li> <li>Heart Attack</li> <li>Kidney Failure</li> <li>Liver Cirrhosis</li> <li>Vital Organ Transplant</li> <li>Alzheimer's Disease</li> <li>Amyotrophic Lateral Sclerosis</li> <li>Aplastic Anemia</li> <li>Bacterial Meningitis</li> <li>Benign Brain Tumor</li> </ol>	disease/ailment is covered)  Cardiomyopathy Coma	<ul> <li>Multiple Sclerosis</li> <li>Muscular Dystrophy</li> <li>Paralysis</li> <li>Parkinson's Disease</li> <li>Poliomyelitis</li> <li>Primary Pulmonary Arterial Hypertension</li> <li>Progressive Bulbar Palsy</li> <li>Progressive Muscular Atrophy</li> <li>Severe Brain Damage</li> <li>Surgery to Aorta</li> <li>Terminal Illness</li> </ul>		
a. Date of first consultation:	mm / dd / yyyy	Total and Permanent Disability		
b. How long has the patient been experiencing said illness from the date of his/her first consultation? (state duration in months) m m				

c. Provide full and exact details of diagnosis

(please attach corresponding medical document for diagnosis or use back sheet if necessary)



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#### **PHYSICIAN'S STATEMENT** (To be filled up only by a licensed Physician) Continuation

d. What are its contributory causes?

2. Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests)

a. Date of test	mm / dd / yyyy	b. Type of Test	
Details:			
3 is the national canable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)?			

3. Is the patient capable of performing activities of daily living (batning, dressing up, eating, getting in/out of be

If no, please state relevant period.

mm / dd / yyyy

Until	
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mm / dd / yyyy

a. What activities can the patient not perform?

4. To your knowledge, has the patient been hospitalized or attended to for any other medical condition? Yes No If yes, please give details.

Name of Doctor/Hospital	Complete Address	Dates Attended	Disease or Condition

5. Are you the patient's regular attending phsician? Yes No If yes, please give details on the patient's past health history.



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#### **PHYSICIAN'S STATEMENT** (To be filled up only by a licensed Physician) Continuation

Please answer with a YES or NO	YES	NO
6. Is the patient's condition a mental or nervous disorder?		
7. Is the treatment related to pregnancy, miscarriage, abortion or childbirth?		
8. Is the condition sustained from being intoxicated or under the influence of drugs?		
9. Is the condition sustained from alcoholism or drug addiction?		
10. Is the treatment for routine physical check-up, rest cure, or special nursing care?		
11. Is the patient's condition congenital?		
12. Is the treatment for cosmetic reasons, a dental treatment or an elective surgery?		
13. Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility?		$\square$
14. Is the patient's condition AIDS-related or due to a sexually transmitted disease?		$\square$
15. Is the patient's condition an intentionally self inflicted injury or in the intention of suicide or any attempt thereat, while sane or insane?		
16. Is the patient's condition a result of homicide, frustrated homicide or any attempt there of,	_	_
or physical injuries, occassioned by the provocation of the Name Insured?		

17. State the hospital name where the patient has/have been confined/ consulted in connection with the mentioned illness/loss:

Name of Hospital	Address (City and Province)	Date of Admission	Date of Discharge
		mm / dd / yyyy	mm / dd / yyyy
		mm / dd / yyyy	mm / dd / yyyy
		mm / dd / yyyy	mm / dd / yyyy

18. Please provide details of physicians to whom the patient had been referred, or who attended to the patient.

Name of Doctor	Complete Address	Dates Attended	Nature of Disease or Condition

# 19. If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.



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#### **PHYSICIAN'S DECLARATION**

I,	Physician's Name in Full: Last	Name, First Name, Middle Name		
a graduate of		Medical College		
in the year	with License No.			
hereby truthfully	hereby truthfully certify that the answers given above are full, complete and true.			
		Witnessed by:		
Physician's Sign	ature			
T Hysician's Signa				
Date Signed:	mm / dd / yyyy	Printed name and signature of witness		
Place Signed:				
Mobile Number:	(09XX-XXXXXX)			
Clinic Address:				
Clinic Hours:				

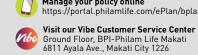
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