ATTENDING PHYSICIAN'S STATEMENT TOTAL AND PERMANENT DISABILITY CLAIM



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 Na	ame						
Address:							
Occupation:							
Gender: Male	Female						
Date of Birth: Weight:							
mm / dd / yyyy							
MEDICAL HISTORY							
 Are you the insured's regular physician?							
3. When did you first attend to the insured for his/her present illness/injury?	vvvv						
4. Have you previously attended to the insured? Yes No If yes, please describe below.	<u>.</u>						
When For what							
mm / dd / yyyy							
mm / dd / yyyy							
5. Has the insured been treated by any other physician? Yes No If yes, give their names and addresses.							
Name of Physician Address Date Na	ture of Disease						
mm / dd / yyyy							
mm / dd / yyyy							



Chat with Bessie, for your policy-related concerns and other questions. Simply go to https://m.me/BessieofBPIAIA/.



Send an email to **BPIAIA.CustomerService@aia.com** for your inquiries and feedback.



Talk to a **Bancassurance Sales Executive** at any BPI or BPI Family Savings Bank branch.



Call our customer hotline at **(02) 8528-5501** from Mon.-Fri., 8AM-5PM, except holidays.



MEDICAL HISTORY Continual	tion		
6. Has the insured received treat If yes, state where.	ment in any hospital, sanitarium o	or institutions? Y	es No
Name of Hospital	Address	Date	Treatment Received
		mm / dd / yyyy	
		mm / dd / yyyy	
7. What and when was the earlies	st indication of illness noted by th	e injured? Give your b	pasis.
8. When in your opinion, did the i	llness which directly or indirectly	caused the disability	commence?
9. Was the insured in good health If not, give details.	n up to the time of his/her presen	t illness?) No
in not, give detailes.			
DISABILITY			
10. How would you classify the ins	ured's disability?		
Total Permanent Pa	artial Permanent 🔃 Total Tem	porary Partial 7	Temporary
If partial, what in your opinion	is the degree of incapacity?		
11. If totally disabled, since when?	mm / dd / yyyy		
12. Is the injured totally disabled n	low? Yes No		







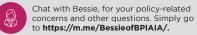


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DIAGNUSIS				
3. What is your diagnosis?				
Interpretation, if any, of:				
(a) Laboratory reports:				
(b) X-ray:				
(c) Electrocardiogram:				
(c) Liceti ocal alogi alii.				
4. Was there any predisposing or occupation or previous illness	contributing cause, remote of the insured? \(\bigcap \) Yes	or recent, for the present disab No	ility in the family history,	
If yes, describe fully.				
		10 0 10		
15. Is any surgical procedure/oper If yes,	ation contemplated on or na	s one been performed?	S No	
What	When	Where	By whom	
	mm / dd / yyyy			
	mm / dd / yyyy			
	mm / dd / yyyy			















PROGNOSIS		
l6. What is the pr	rognosis?	
.=		
7. When, in your	r opinion, can the insured resume his/her usual occupation or employment?	
PHYSICIAN'S	DECLARATION	
l,		
	Physician's Name in Full: Last Name, First Name, Middle Name	
a graduate of	Medical College	
in the year	with License No.	
hereby truthfull	lly certify that the answers given above are full, complete and true.	
	Witnessed by:	
Physician's Sign	inature	
i nysician s sign	Printed name and signature of witness	
Date Signed:	mm / dd / yyyy	
Place Signed:		
Mobile Number	(O9XX-XXXXXXX)	
Clinic Address:		
Clinic Hours:		
Cume mours:		

QR-BCLC-TPDC / REV 0 / JUNE 2025

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