ATTENDING PHYSICIAN'S STATEMENT
TOTAL AND PERMANENT DISABILITY CLAIM

BPI AIA

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*

Address:

Occupation:

Gender: ☐ Male ☐ Female

Date of Birth: *mm / dd / yyyy*

Height:

Weight:

MEDICAL HISTORY

1. Are you the insured's regular physician? ☐ Yes ☐ No
2. How long have you known the injured for his/her present illness/injury?
3. When did you first attend to the insured for his/her present illness/injury? *mm / dd / yyyy*
4. Have you previously attended to the insured? ☐ Yes ☐ No
   If yes, please describe below.

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	Nature of Disease
		mm / dd / yyyy	
		mm / dd / yyyy	

MEDICAL HISTORY *Continuation*

6. Has the insured received treatment in any hospital, sanitarium or institutions? ☐ Yes ☐ No
   If yes, state where.

Name of Hospital	Address	Date	Treatment Received
		mm / dd / yyyy	
		mm / dd / yyyy	

7. What and when was the earliest indication of illness noted by the injured? Give your basis.

8. When in your opinion, did the illness which directly or indirectly caused the disability commence?

9. Was the insured in good health up to the time of his/her present illness? ☐ Yes ☐ No
   If not, give details.

DISABILITY

10. How would you classify the insured's disability?
    ☐ Total Permanent ☐ Partial Permanent ☐ Total Temporary ☐ Partial 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 now? ☐ Yes ☐ No

DIAGNOSIS

13. What is your diagnosis?

Interpretation, if any, of:

(a) Laboratory reports:

(b) X-ray:

(c) Electrocardiogram:

14. Was there any predisposing or contributing cause, remote or recent, for the present disability in the family history, occupation or previous illness of the insured? ☐ Yes ☐ No
If yes, describe fully.

15. Is any surgical procedure/operation contemplated on or has one been performed? ☐ Yes ☐ No
If yes,

What	When	Where	By whom
	mm / dd / yyyy		
	mm / dd / yyyy		
	mm / dd / yyyy		

PROGNOSIS

16. What is the prognosis?

17. When, in your opinion, can the insured resume his/her usual occupation or employment?

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 certify that the answers given above are full, complete and true.

Witnessed by:

Physician's Signature

Printed name and signature of witness

Date Signed: *mm / dd / yyyy*

Place Signed:

Mobile Number: *(09XX-XXXXXXX)*

Clinic Address:

Clinic Hours: