PHILAM LIFE
An AIA Group Company

ATTENDING PHYSICIAN STATEMENT-CRITICAL ILLNESS/DISMEMBERMENT CLAIM FORM

15F-18F Net Lima Building, 5th Avenue corner 26th Street, Bonifacio Global City, Taguig 1634

NOTE: Fill out ☐ with block letters. Put ☒ on the tick boxes representing options. Please use an addendum if spaces provided are not enough.

Agent Code

PATIENT INFORMATION

PATIENT LAST NAME | M.I. | Date of Birth (mm/dd/yyyy) | Sex: ☐ Male ☐ Female

PATIENT FIRST NAME | Are you related to the patient? If "yes" please state relationship.

PHYSICIAN STATEMENT (To be filled up only by a licensed Physician)

1. Name the Critical illness/Dismemberment the patient is experiencing: (please refer to insured's policy contract if disease/ailment is covered)

☐	Cancer of the_____	☐	Cardiomyopathy	☐	Multiple Sclerosis
☐	Cerebrovascular Stroke	☐	Coma	☐	Muscular Dystrophy
☐	Coronary Artery Bypass Surgery	☐	Encephalitis	☐	Paralysis
☐	Heart Attack	☐	Fulminant Viral Hepatitis	☐	Parkinson's Disease
☐	Kidney Failure	☐	Heart Valve Replacement	☐	Poliomyelitis
☐	Liver Cirrhosis	☐	Loss of Hearing	☐	Primary Pulmonary Arterial Hypertension
☐	Vital Organ Transplant-_____	☐	Loss of Limbs	☐	Progressive Bulbar Palsy
☐	Alzheimer's Disease	☐	Loss of Sight	☐	Progressive Muscular Atrophy
☐	Amyotrophic Lateral Sclerosis	☐	Loss of Speech	☐	Severe Brain Damage
☐	Aplastic Anemia	☐	Loss of _____	☐	Surgery to Aorta
☐	Bacterial Meningitis	☐	Major Burns	☐	Terminal Illness
☐	Benign Brain Tumor	☐	Motor Neuron Disease	☐	Total and Permanent Disability

a. Date of first consultation: m m / d d / y y y y

b. How long have the patient been experiencing such illness from the date of your first consultation? (state duration in months) m m

c. Provide full and exact details of diagnosis.(please attach corresponding medical document for diagnosis and use back sheet if you need more space)

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 m m / d d / y y y y

b. Type of Test

Details:

3. Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? If "no" please state relevant period.

From m m / d d / y y y y Until m m / d d / y y y y

a. Which activities the patient is not able to perform?

4. To your knowledge, has the patient been hospitalized or attended to for any other medical condition? 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? If "yes" please give details on the patient's past health history.

PHYSICIAN STATEMENT (To be filled up only by a licensed Physician) Continuation

Please answer by 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?		
14. Is the patient's condition AIDS-related or due to a sexually transmitted disease?		
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 (mm/dd/yyyy)	Date of Discharge (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.

THIS FORM IS ACCOMPLISHED BY

Place Signed

Date: m m / d d / y y y y

Physician's Signature

Physician's Printed Name

Physician's PRC License Number

Mobile Number

Witness Printed Name

Physician's Clinic Address

Clinic Hours:

Witness Signature

PLEASE DO NOT SIGN ON A BLANK FORM.