

Policy No.

**ATTENDING PHYSICIAN'S STATEMENT FOR LIVING BENEFITS**

**IMPORTANT NOTICE**

This statement must be made by the attending physician of the insured. If more than one physician was employed, the statement of each must be furnished upon on separate forms, which will be sent if required. Indefinite terms as heart failure, exhaustion and the like are to be avoided unless full details are added. Where the spaces set apart for the answers are too small, such details as seem desirable may be given on a separate sheet.

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 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 present or use the same, or to allow it to be presented in support of any claim.

**GENERAL INFORMATION**

Patient's name \_\_\_\_\_

Name of hospital \_\_\_\_\_

Address of hospital \_\_\_\_\_

Contact nos. of hospital \_\_\_\_\_ Ward/Room no. \_\_\_\_\_

Date and time of admission \_\_\_\_\_ Date and time of discharge \_\_\_\_\_

Are you related to the patient by blood or consanguinity? \_\_\_\_\_ If yes, how? \_\_\_\_\_

Are you the regular physician of the patient? \_\_\_\_\_ If yes, since when? \_\_\_\_\_

Did any other physician attend to the patient? \_\_\_\_\_ If yes, please give details below:

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**DETAILS OF THE ILLNESS**

Describe the nature and symptoms of the patient's illness/disease \_\_\_\_\_

Date the symptoms first occurred \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

Is the disease /illness congenital or hereditary? \_\_\_\_\_

Was recovery uncomplicated and was the period of hospitalization normal for a case of this type?  Yes  No

If not, what factors hampered recovery and lengthened the period of hospitalization? \_\_\_\_\_

What is the patient's progression?  Recovered  Improved  Unchanged  Retrogressed

Is there a possibility of a relapse?  Yes  No . If yes, please explain \_\_\_\_\_

**Details of previous consultations**

Date of Consultation	Illness / Diagnosis	Procedure / Operation Done	Prescribed Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

From what other illness or disease did the insured suffer? Please give, as nearly as you can, the duration of each one

\_\_\_\_\_

\_\_\_\_\_

**DETAILS OF ACCIDENT**

What is the cause of the injury \_\_\_\_\_

Date and time of the accident \_\_\_\_\_

Did loss/es or disability occur from bodily injury caused solely by the accident?  Yes  No. If no, give details of contributory cause/s.

\_\_\_\_\_

Was the patient under the influence of alcohol/medication at the time of accident?  Yes  No. If yes, please give details.

\_\_\_\_\_

**PATIENT'S CONDITION**

What is the patient's present medical condition?

Is said condition a sole and direct result of the injury/ies sustained from the accident?  Yes  No

Is the patient considered to be disabled because of such condition?  Yes  No. If yes, for how long will the patient be disabled?

\_\_\_\_\_

Is such disability  Temporary?  Total & Permanent? Please explain. \_\_\_\_\_

\_\_\_\_\_

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What further complications can be expected? \_\_\_\_\_

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#### PATIENT'S IMPAIRMENTS

Rate/Classify and describe the PHYSICAL impairment/s of the patient as to functional capacity and its limitations.

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Rate/Classify and describe the MENTAL/NERVOUS impairment/s of the patient as to functional capacity and its limitations.

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#### PATIENT'S PROGNOSIS AND REHABILITATION

Is the patient now totally able to resume his/her current work?  Yes  No. If yes, please explain.

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If no, when will the patient be able to return to work? \_\_\_\_\_

Is there a chance for total recovery?  Yes  No. If yes, when do you expect the patient to recover suitably and return to work?

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If no, please explain \_\_\_\_\_

In case the patient is unable to resume his/her current occupation, can he/she be able to engage in other occupations/businesses?

Yes  No. If yes, what would be his/her functional capacity and limitations, if any?

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If patient is suitable for other employment, what type of employment would you suggest?

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If not, please explain. \_\_\_\_\_

#### DETAILS OF THERAPY

Is the patient currently undergoing or has he/she undergone therapy sessions?  Yes  No. If yes, please provide details.

Type of Therapy

Period of Sessions

Name of Therapist

Address & Contact No.

Any improvement noted during each therapy? Please elaborate. \_\_\_\_\_

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**FOR FEMALES ONLY**

Was the patient pregnant at the time of hospitalization/accident? \_\_\_\_Yes \_\_\_\_No. If yes, for how many months? \_\_\_\_\_

Was the hospitalization caused directly or indirectly by pregnancy/childbirth? \_\_\_\_Yes \_\_\_\_No. Please explain.

\_\_\_\_\_

Having been duly sworn, I hereby depose and say that all the statements in the foregoing answers are true and full, to the best of knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Name and Signature of Witness

\_\_\_\_\_  
Printed Name & Signature of Attending Physician  
License No. \_\_\_\_\_

\_\_\_\_\_  
Address and contact no.

\_\_\_\_\_  
Address and contact no.

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ personally appeared before me the above named \_\_\_\_\_, who being by me duly sworn, deposed that the answers to the above questions are full and true, to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

Affiant exhibited to me his/her Residence Certificate No. \_\_\_\_\_ issued at \_\_\_\_\_ on \_\_\_\_\_.

NOTARY PUBLIC

Doc.No. \_\_\_\_\_;  
Page No. \_\_\_\_\_;  
Book No. \_\_\_\_\_;  
Series of \_\_\_\_\_.

THIS STATEMENT MUST BE MADE BEFORE A NOTARY PUBLIC OR OTHER OFFICER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A MUNICIPAL JUDGE OR BY THE CLERK OF COURT OF RECORD.