ATTENDING PHYSICIAN'S STATEMENT DISABILITY CLAIM

IMPORTANT: All answers must be entirely in the Physician's own handwriting.
Any expense/s incurred on the issuance of this statement shall be borne by the insured / patient.

1.	Full Name of patient	
2.	Residence of patient	
3.	Occupation of patient at time of disability	
4.	Did you attend or were you consulted by the patient before the present illness / injury? If yes, Please provide details.	
5.	Was the disability caused by illness or injury?	
6.	a. Date of disability	
	b. Place of disability	
7.	Please describe fully the illness / injury and its severity:	
8.	Please indicate approximate date from which the patient first notice symptoms of present condition:	Any laboratory procedures performed? If yes, please provide details.
9.	How would you classify the disability? (Total Permanent / Total Temporary / Partial Permanent / Partial Temporary)	
10.	Has the patient been treated previously for this condition? If yes, please provide details.	
11.	Duration of Disability. If duration for recovery is more than the usual, please explain why.	
13.	Given the current condition & extent of disability the patient has suffered, when can he/she resume his/her usual occupation?	
14.	Given the extent of the disability the patient has suffered, will it prevent him/her performing any kind of work outside his/her usual occupation?	
15.	Given the extent of the disability of the patient presently has suffered, which one of the following activities of daily living he/she cannot perform? (1) continence (2) dressing (3) bathing (4) feeding (5) mobility or transferring in or out of a chair, bed or to walk.	
16.	Was there any special connection (remote or proximate) between the disability and personal history, habits, occupation or residence of the patient? If yes, please state which and give particulars.	
17.	Was disability due to accident? If yes, please provide details.	
18.	Was the patient under the influence of liquor or prohibited drugs at the time of accident / incident?	
19.	Evidence of any permanent disability the patient sustained as a result of the illness / injury.	

20. Please provide details of any surgical operations performed or contemplated to be performed to the patient:

Date of Operation	Name of Physician and Hospital	Type of Operation

21. Names and addresses of other physicians that treated the patient for this illness / injury.

Name of Physician / Hospital / Institution	Address	Contact Numbers	Dates Attended

12.	Additional Remarks	

DECLARATION:
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION:
I further authorize the Medical Director or any of his/her authorized representatives to furnish PHILIPPINE LIFE FINANCIAL ASSURANCE CORPORATION or its authorize representatives all medical records of the patient. A photographic copy of this authorization is valid as the original.

_____ _____
Signature over Printed Name of the Attending Physician Date

Specialization: _____
License No: _____
Contact Numbers: _____