

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)

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

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

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 / / / / / / / Until / / / / / / / m m d d y y y y 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 physician? 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? YES NO
- 7. Is the treatment related to pregnancy, miscarriage, abortion or childbirth? YES NO
- 8. Is the condition sustained from being intoxicated or under the influence of drugs? YES NO
- 9. Is the condition sustained from alcoholism or drug addiction? YES NO
- 10. Is the treatment for routine physical check-up, rest cure, or special nursing care? YES NO
- 11. Is the patient's condition congenital? YES NO
- 12. Is the treatment for cosmetic reasons, a dental treatment or an elective surgery? YES NO
- 13. Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility? YES NO
- 14. Is the patient's condition AIDS-related or due to a sexually transmitted disease? YES NO
- 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? YES NO
- 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? YES NO
- 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.