

Living Benefit

Attending Physician's Statement



In this form, **you** and **your** refer to the physician who attended to the patient, while **we, us, our** and the **Company** refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life group of companies.

Sections 1-3 are required. For Sections 4 and onwards, please answer only the questions applicable to the patient's case.

1 Information about the Patient

| | |
|---|--------------------------------|
| Name of Patient (Last Name, First Name, M.I.) | Date of Birth (month/day/year) |
|---|--------------------------------|

2 Details of Condition

| | |
|--|--|
| Date symptoms and signs were first experienced and noticed by the patient (month/day/year) | Symptoms experienced and signs noticed |
| Date you first attended to the patient (month/day/year) | Reason for consultation |

Was the patient attended by any other physician/specialist for these symptoms and signs before and after he/she consulted you?

Yes No If "Yes", please provide the details below:

| Name of Physician/Specialist (e.g. MD, ROT, LPT) | Name of Hospital/Medical Facility | Date Attended (month/day/year) |
|--|-----------------------------------|--------------------------------|
| | | |
| | | |

If the space is insufficient, use the back page of this form.

| | |
|---|----------|
| Diagnosis (if applicable, please indicate the stage) | ICD Code |
| Medical tests/procedures performed supporting the diagnosis (Please include the dates) | |
| Was the patient or his/her next of kin informed of the above diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide the date (month/day/year) _____ | |

Was the patient hospitalized for this condition? Yes No If "Yes", please provide the details below:

| | |
|------------------------------------|------------------------------------|
| Date of Admission (month/day/year) | Date of Discharge (month/day/year) |
| Name and address of hospital | |

Was the patient transferred to another hospital/facility for further test/procedure? Yes No If "Yes", please provide the details below:

| | |
|------------------------------------|------------------------------------|
| Date of Admission (month/day/year) | Date of Discharge (month/day/year) |
| Name and address of hospital | |

3 Details of Treatment/Consultation

List all the dates when the patient consulted and was treated.

| Date of Consultation/ Treatment (month/day/year) | Vital Signs (Blood Pressure, Temperature, etc.) | Symptoms Experienced and Signs Noticed | Date Symptoms and Signs First Noticed (month/day/year) | Diagnosis/Remarks | Medication Prescribed and Other Treatment Modalities |
|--|---|--|--|-------------------|--|
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If the space is insufficient, use the back page of this form.

What medical history was disclosed to you by the patient?

| Diagnosis/Illness (Please enumerate all) | Date of Diagnosis/Illness | Name of Attending Physician/ Specialist | Name of Hospital/Clinic | Medication Prescribed and Other Treatment Modalities |
|---|------------------------------|--|-------------------------|--|
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If the space is insufficient, use the back page of this form.

Smoking Habit

To your knowledge, did the patient smoke? Yes No If "Yes", please provide details below:

Start date (month/day/year): _____ End date (month/day/year): _____

Source of information: _____ Relationship (other than the patient): _____

4 Neurological-related questions

Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? Yes No

If "No", please provide details.

| Activities of Daily Living | | Since when (month/day/year) | Expected Recovery (month/day/year) |
|----------------------------|--|-----------------------------|---------------------------------------|
| Washing/bathing | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |
| Dressing | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |
| Transferring | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |
| Toileting | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |
| Feeding | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |
| Mobility | <input type="checkbox"/> With assistance <input type="checkbox"/> Without assistance | | |

Did the patient's condition result in any major, permanent neurological deficit that will require physical rehabilitation? Yes No

If "Yes", please provide details.

| Neurological Deficit | Severity (Mild, Moderate, Severe) | Start Date (month/day/year) | End Date (month/day/year) | Date of Expected Recovery if deficit still persists (month/day/year) |
|----------------------|--------------------------------------|--------------------------------|------------------------------|---|
| | | | | |
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Glasgow Coma Score for seven (7) consecutive days

| Date (month/day/year) | Glasgow Coma Score |
|-----------------------|--------------------|
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| | |

For Severe Myasthenia Gravis, please provide full details of diagnosis using appropriate clinical classification.

If the diagnosis is **Deafness**, is the loss of hearing in both ears total and irreversible? Yes No

If the diagnosis is **Blindness**, is the loss of all vision in both eyes total permanent and irrecoverable? Yes No

If the diagnosis is **Loss of Speech**, is the loss of the ability to speak total and irrecoverable? Yes No

If the diagnosis is **Elephantiasis**, is the lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities? Yes No

If the patient was diagnosed with a **Terminal Illness**, what is the predicted survival period from date of diagnosis (life expectancy)? _____

When did patient cease to work because of incapacity? (month/day/year) _____

How would you describe the patient's condition since onset of disability?

Improved Remained the same Slight deterioration Significant deterioration

How would you describe the current physical, cardiac and mental/nervous impairment of the patient?

| Class | Physical Impairment | Cardiac Functional Classification (NYHA Classification) | Mental/Nervous Impairment |
|-------|--|---|--|
| 1 | <input type="checkbox"/> No limitation, capable of physical activities (1-10%) | <input type="checkbox"/> No limitation; ordinary physical activity does not cause undue fatigue, palpitation or shortness of breath | <input type="checkbox"/> Patient is able to function under stress and engage in interpersonal relations. |
| 2 | <input type="checkbox"/> Slight limitation, capable of light manual activities (15-30%) | <input type="checkbox"/> Slight limitation; Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, shortness of breath or chest pain. | <input type="checkbox"/> Patient is able to function in most situations and engage in most interpersonal relations. |
| 3 | <input type="checkbox"/> Moderate limitation, capable of clerical/administrative (sedentary) activities (35-55%) | <input type="checkbox"/> Marked limitation; Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, shortness of breath or chest pain. | <input type="checkbox"/> Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. |
| 4 | <input type="checkbox"/> Marked limitation (60-70%) | <input type="checkbox"/> Complete limitation; Symptoms of heart failure at rest. Any physical activity causes further discomfort. | <input type="checkbox"/> Patient is unable to engage in stressed situations or engage in interpersonal relations. |
| 5 | <input type="checkbox"/> Severe limitation, incapable of minimal activities (75-100%) | | <input type="checkbox"/> Patient has significant loss of psychological, physiological, personal and social adjustment. |

Is patient currently able to resume work?

Yes

On own occupation, since (month/day/year) _____

On other occupation, since (month/day/year) _____

No

When do you expect patient to recover to resume work? (month/day/year) _____

What type of occupation can patient perform? Why?

Please complete all the fields below:

| | |
|-----------------------------|--|
| Signature of Physician X | Printed Full Name |
| Field of Specialization | Date (month/day/year) and Place Signed |
| Address | Clinic Hours |
| Contact Number | E-mail Address |
| PTR No. | License No. |