

Attending Physician's Statement (Accidental Dismemberment & Disablement)



Please PRINT clearly.
If with erasures,
please countersign.

In this form, "you" and "your" refer to the policyowner, life insured, patient and the physician whose information we are processing or disclosing. We, us, our and the Company refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life Financial group of companies.

The patient is responsible for the completion of this form without expense to the Company.

1 General Information (to be completed by the Patient)

Relating to the Patient

Policy Number/s	
Name (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (month/day/year)	
Residence Address	
Contact Number/s	E-Mail Address
Policyowner (Please complete if policyowner is other than the life insured)	

Authorization By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs. If you need more information about our privacy policy, please visit https://apps.sunlife.com.ph/privacy .	Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent
		Date of Signing (month/day/year)

2 Physician or Surgeon's Statement

1. Losses suffered by patient	Date of Loss (month/day/year)	Extent of Loss	Yes	No
<input type="checkbox"/> sight of one eye <input type="checkbox"/> hearing of one ear	<input type="checkbox"/> both eyes <input type="checkbox"/> both ears	_____ _____ Is loss of sight total and irrecoverable? Is loss of hearing total and irrecoverable?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> one hand <input type="checkbox"/> one arm <input type="checkbox"/> four fingers and thumb of one hand <input type="checkbox"/> four fingers <input type="checkbox"/> thumb <input type="checkbox"/> metacarpals of 1st and 2nd (additional) <input type="checkbox"/> metacarpals 3rd, 4th or 5th (additional)	<input type="checkbox"/> both hands <input type="checkbox"/> both arms <input type="checkbox"/> index finger <input type="checkbox"/> middle finger <input type="checkbox"/> ring finger <input type="checkbox"/> little finger	_____ _____ _____ _____ _____ _____ _____ Was severance at or above wrist? Was severance at or above elbow? Was severance at or above the metacarpophalangeal joints?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> one foot <input type="checkbox"/> one leg <input type="checkbox"/> all toes on one foot <input type="checkbox"/> big toe <input type="checkbox"/> any toe other than big toe, each	<input type="checkbox"/> both feet <input type="checkbox"/> both legs	_____ _____ _____ _____ _____ Was severance at or above ankle? Was severance at or above knee? Was severance at or above the metatarsophalangeal joints?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If any question under "Extent of Loss" is answered "No", please give details.				

2. Details of Accident

Date of Accident (month/day/year)	
Did losses or disability occur from bodily injury caused solely by accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, give details of contributory causes.



2 Physician or Surgeon's Statement (continued)

3. Details of Treatment

Date of first treatment following accident (month/day/year)	Was the patient treated in any hospital/clinic/institution? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date of Admission (month/day/year)	Name and Address of Hospital
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Details of surgical treatment, if any.

Date surgery was performed (month/day/year)	Name and address of Surgeon	Type of surgical treatment
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4. Patient's Progress

Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> Hospital Confined?			
Describe briefly the patient's present condition.		Is this condition a sole and direct result of that injury/accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What further complications can be expected?			
State how long will the patient be disabled.			

5. Cardiac (If Applicable)

Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)			
Blood Pressure (last visit)		Systolic	Diastolic

6. Physical Impairment

<input type="checkbox"/> Class 1 - No limitation of functional capacity, capable of physical activity (0-10%)	<input type="checkbox"/> Class 4 - Marked limitation (60-70%)
<input type="checkbox"/> Class 2 - Slight limitation of functional capacity, capable of light manual activity (15-30%)	<input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimal (sedentary) activity (75-100%)
<input type="checkbox"/> Class 3 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity (35-55%)	

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

Remarks

7. Mental/Nervous Impairment

<input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitation)	<input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
<input type="checkbox"/> Class 2 - Patient is able to function in most situations and engage in most interpersonal relations (slight limitation)	<input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)
<input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)	

Remarks

2 Physician or Surgeon's Statement (continued)

8. Prognosis

	Patient's Job	Any Other Work
Is patient now totally incapacitated to resume work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No", when was patient able to return to work?	(month/day/year)	(month/day/year)
If "Yes", when do you expect patient will recover sufficiently to resume work?	(month/day/year)	(month/day/year)

9. Rehabilitation

	Patient's Job	Any Other Work
Is patient a suitable candidate for trial employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", when can trial employment commence?	(month/day/year)	(month/day/year)
	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
If "Yes", what type of employment would you suggest? If "No", please explain		

Would further communication with our Medical Director be beneficial?

Yes No

10. Smoking Habit Information

Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product? Yes No

a. If "Yes", fill out appropriate box with quantity per day.

cigarettes	E-cigarettes	cigars	others
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b. If "No", has the patient ever smoked a cigarette/cigarillo/cigar or consumed any other tobacco product in the past? Yes No

If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product? month/year

11. Additional Information

Are you the patient's attending physician for this injury/condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	When did you first see the patient for this injury/condition? (month/day/year)	
Did you attend to him/her for any other illness or accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", for what illness or accident and when? (month/day/year)	Was the patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", state the name of the other doctors who have attended to the patient.	
How long have you been in active practice?	Are you related to the patient by blood or by affinity? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how?

12. Other Comments/Remarks

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3 Signatures

Signature of Physician X	Printed Name		
Field of Specialization	License No.	PTR No.	
Medical Office Address			
Contact Number/s	E-mail Address		
Clinic Hours	Date of Signing (month/day/year)	Place of Signing	