Hospital Income Benefit (HIB) Attending Physician's Statement

Sun Life

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

1 Information about the Life Insured

Name of Insured (Last Name, First Name, M.I.)	Date of Birth (Month/Day/Year)

2 Details of Confinement

Diagnosis	
Why did you recommend confinement (e.g. symptoms or complaints prior to admission)?	
Date of Admission (Month/Day/Year)	Date of Discharge (Month/Day/Year)
Name and address of hospital	

During the confinement, were there other physicians who gave treatment? ☐ Yes ☐ No If "Yes," please provide the details below:

Name of the Physician	Field of Specialization

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

3 Details of Treatment / Consultation

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

Date of Consultation/ Treatment (Month/Day/Year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/Remarks	Medication Prescribed/ Treatment

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

Was the insured patient or his/her next of kin informed of the above findings/diagnosis? ☐ Yes ☐ No

Did the insured patient suffer from any other illness, disease, or condition? ☐ Yes ☐ No If "Yes," please provide the details below:

Date of Illness (Month/Day/Year)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/ Remarks	Attending Physician/Hospital	Medication Prescribed/ Treatment

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

Smoking Habit

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

Start date (Month/Day/Year): _____ End date (Month/Day/Year): _____ ☐ Until time of death

Source of information: _____ Relationship with the deceased insured: _____

4 Physician's Signature

Signature of Physician X	Printed Full Name	Field of Specialization	PTR & License Nos.
Address	Contact Number	E-mail Address	Date (Month/Day/Year) and Place Signed