Attending Physician's Statement (Female and Maternity Benefits)

Sun Life Financial

Please PRINT clearly.
If with erasures,
please countersign.

In this form, "*you*" and "*your*" refer to the policy owner, 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 Sun Life of Canada (Philippines), Inc.

1 General Information (to be completed by the patient)

I. Relating to the Patient

Policy Number/s	
Name (Last, First, M.I.)	Date of Birth (month/day/year)
Residence Address	
Contact Number/s	E-mail Address
Policyowner (last name, first name, M.I.) - 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.a. Date on which you first attended the patient (month/day/year)	1.b How long do you believe the symptoms had been present when you were first consulted?	1.c When was the patient informed of the diagnosis? (month/day/year)

2. Give full and exact details of the diagnosis. If cancer, please specify the stage.

3. a Had the patient had any past history of the disease specified above or related condition? ☐ Yes ☐ No If *Yes*, give details.

b Are you the patient's usual medical attendant? ☐ Yes ☐ No If *Yes*, give details.

Period of Consultation

Past Health History

4. Is there anything in the patient's family history which would have increased the risk of her condition? ☐ Yes ☐ No If *Yes*, give details.

5. Please describe the underlying cause of the patient's condition.

2 Physician or Surgeon's Statement - continued

6. Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, E. C. G., MRI or any other special tests with dates).

7. Please provide details of physicians to whom the patient has been referred or who attended to the disease.

Name of Physician(s)	Address (Clinic/Hospital)

8. Please provide details of the patient's habits in relation to smoking.

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

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

9. Is the patient suffering from, or, has the patient undergone any of the following?

- ☐ Cervical intraepithelial neoplasm (cervix carcinoma in situ)
- ☐ Lobular carcinoma of the non-invasive type (breast carcinoma in situ)
- ☐ Hysterectomy due to therapeutic or elective abortion, embedded intrauterine device or other contraceptive instruments, aesthetic indications or sex change
- ☐ Dilatation and Curettage due to therapeutic or elective abortion, embedded intrauterine device or any other contraception means, investigation of fertility or bleeding after intercourse
- ☐ Surgery for cosmetic reasons
- ☐ Surgery due to correction of facial disfigurement
- ☐ Dissemintated Intravascular Coagulation from abortion or arising during the first seven (7) months of pregnancy

10. Is the patient capable of performing the activities of daily living? ☐ Yes ☐ No

If no, what activities of daily living is the patient unable to perform?

Activities of Daily Living	Since when? (month/day/year)	Expected Recovery (month/day/year)
☐ Washing		
☐ Dressing		
☐ Transferring		
☐ Toileting		
☐ Feeding		

11. Other comments/remarks

3 Signature

Signature of Attending Physician X		Printed Name of Attending Physician
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