Attending Physician's Statement (Living Benefit Rider)



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 Life Insured Information (to be comp Relating to the Person Insured/Patient	leted by the patie	nt)				
Name (Last, First, M.I.)			☐ Male ☐ Female	Date of Birth (month/day/year)		
Residence Address						
Contact Number/s				E-mail Address		
Policy Number Group, specify:	Certificate No.:		Individua	l, specify:		
Authorization: By signing below, you allow us to process ar personal and sensitive personal information to the	Signature of Patient (or Parent, if minor	ture of Patient (or Parent, if minor) Printed Name of Patient/Parent				
we can better help you meet your lifetime needs. If you need more information about our privacy p https://apps.sunlife.com.ph/privacy.		Date of Signing (month/day/year)				
2 Specific Information Requested (to	be completed by	the Attending Physician)	·			
Date of First Visit (month/day/year)	Date of Last Visit (month/day/year)		Frequency of Treatments			
Initial Date of Diagnosis (month/day/year)		How long have you been atte	How long have you been attending the patient?			
Names and Addresses of Other Attending Physicians						
Name		Address				
Diagnosis	Present Condition		Prognosis			
Predicted Survival Period from date of diagnosis (Life Expectancy)	Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Please Explain Yes No					

2 Specific Information Requested (continued)							
Attendant/Precipitating/Aggravating conditions:							
Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, E.C.G., or any other special tests with dates).							
If hospitalized:							
Names and Addresses of Hospitals		Dates Confined (month/day	/year)	Other Attending Physicians			
How long have you been in active practice?	Are you related to the patient by blood or by affinity?		If so, how?	If so, how?			
	☐ Yes	□ No					
3 Signature							
Signature of Attending Physician		Printed Name					
x							
Field of Specialization		License No.		P.T.R. No.			
Medical Office Address		Clinic Hours		1			
Contact Number/s		E-mail Address					
Place of Signing		Date of Signing (mont	h/day/year)				