

# Attending Physician's Statement (Disability)



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.

Please answer all  
questions in full.

The purpose of this report is to assist us in making a disability determination. In filling out this report, please include sufficient details of history, physical, and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

## 1 General Information (to be completed by the patient)

### Relating to the Life Insured/Patient

Life Insured (Last Name, First Name, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)
Complete Address			Sun Life Policy Number(s)
Home Phone	Business Phone	Cellphone	Email Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month/Day/Year)

<b>Authorization</b> 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 <a href="https://apps.sunlife.com.ph/privacy">https://apps.sunlife.com.ph/privacy</a> .	Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent
		Date of Signing (Month/Day/Year)

## 2 Physician's Statement (to be completed by the Attending Physician)

### I. History

When did symptoms first appear or when did accident happen? (Month/Day/Year)	When did patient cease work because of incapacity? (Month/Day/Year)
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Did patient previously have the same or similar conditions?  Yes  No

If "YES", please state when and describe the conditions.

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If condition is long standing, how would you describe its evolution since onset?			
<input type="checkbox"/> Improved	<input type="checkbox"/> Remained the Same	<input type="checkbox"/> Slight Deterioration	<input type="checkbox"/> Significant Deterioration
Is condition due to injury or sickness arising from patient's employment?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

### Smoking Habits Question

Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product?.....				<input type="checkbox"/> Yes	<input type="checkbox"/> No
a) If "Yes", fill out appropriate box quantity per day					
cigarettes	E-cigarettes	cigars	others		
b) If "No", has patient ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?.....					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes", when did the insured stop smoking?				month/year	

### Other Attending Physicians

Name of Physician	Address
_____	_____
_____	_____
_____	_____



**2 Physician's Statement (to be completed by the Attending Physician) - continued****II. Diagnosis (including any complications and stage of illness)**

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**Subjective Symptoms**

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**Objective Findings (Please attach current x-rays, EKG, laboratory tests and any other clinical findings)**

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**III. Dates of Treatment**

Date of first Visit (Month/Day/Year)	Date of Latest Visit (Month/Day/Year)
Frequency of Visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Others (please specify)	

**IV. Nature of Treatment**

Please include surgery and medications prescribed, if any. If chemotherapy/radiotherapy, please indicate dates & number of sessions.

**V. Progress**

Has patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Remained Unchanged <input type="checkbox"/> Retrogressed
Is patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital Confined
Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please provide name and address of hospital
Date Confined (Month/Day/Year)      Date Discharged (Month/Day/Year)

**VI. 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

**VII. Physical Impairment**

<input type="checkbox"/> Class 1 - No limitation of functional capacity, capable of physical activity (1-10%) <input type="checkbox"/> Class 2 - Slight limitation of functional capacity, capable of light manual activity (15-30%) <input type="checkbox"/> Class 3 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity (35-55%) <input type="checkbox"/> Class 4 - Marked limitation (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimal (sedentary) activity (75-100%)
Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Remarks

**VIII. Mental/Nervous Impairment**

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

## 2 Physician's Statement (to be completed by the Attending Physician) - continued

### IX. Neurological Deficits (If Applicable)

Functional Deficit				
Involved Area				
Severity:	<input type="checkbox"/> Very Mild	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
To what extent has recovery occurred neurologically? Functionally?				
<input type="checkbox"/> 0%	<input type="checkbox"/> 20%	<input type="checkbox"/> 40%	<input type="checkbox"/> 60%	<input type="checkbox"/> 100% <input type="checkbox"/> Others

Please detail the changes and/or limitations caused by the patient's illness

A. Paralysis/Paresis
B. Speech
C. Sensory
D. Neuro-psychological
Do you consider the neurological deficits to remain during patient's lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "NO", what type of work would patient be capable of performing after recuperation?
<input type="checkbox"/> Own occupation prior to disability
<input type="checkbox"/> Other occupation, please specify: _____

### X. Prognosis

<p>IS PATIENT CURRENTLY ABLE TO RESUME WORK? (please check appropriate box)</p> <p><input type="checkbox"/> Yes</p> <ul style="list-style-type: none"> <li>If yes, <input type="checkbox"/> On own occupation prior to disability</li> <li><input type="checkbox"/> On other occupation?</li> </ul> <p>Since when? (Month/Year) _____</p> <p><input type="checkbox"/> No</p> <p>If no, when do you expect patient to recover to resume work? (Month/Year) _____</p> <p>Can patient resume own occupation prior to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what type of occupation can patient perform? Why?</p> <p>_____</p> <p>_____</p>
Other Comments/Remarks

## 3 Physician's Signature

Signature of Attending Physician <b>X</b>		Printed Name	
PTR No.	License No.	Field of Specialization	
Clinic Address		Clinic Hours/Schedule	
Telephone No.		E-mail Address	
Place of Signing		Date of Signing (Month/Day/Year)	