Attending Physician's Statement
(Accidental Dismemberment & Disablement)

Sun Life Financial

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.) ☐ Male ☐ 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
☐ sight of one eye	☐ both eyes		Is loss of sight total and irrecoverable?	☐	☐
☐ hearing of one ear	☐ both ears		Is loss of hearing total and irrecoverable?	☐	☐
☐ one hand	☐ both hands		Was severance at or above wrist?	☐	☐
☐ one arm	☐ both arms		Was severance at or above elbow?	☐	☐
☐ four fingers and thumb of one hand	☐ index finger		Was severance at or above the metacarpophalangeal joints?	☐	☐
☐ four fingers	☐ middle finger				
☐ thumb	☐ ring finger				
☐ metacarpals of 1st and 2nd (additional)	☐ little finger				
☐ metacarpals 3rd, 4th or 5th (additional)					
☐ one foot	☐ both feet		Was severance at or above ankle?	☐	☐
☐ one leg	☐ both legs		Was severance at or above knee?	☐	☐
☐ all toes on one foot			Was severance at or above the metatarsophalangeal joints?	☐	☐
☐ big toe					
☐ any toe other than big toe, each					

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?
☐ Yes ☐ 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? ☐ Yes ☐ No

Date of Admission (month/day/year)	Name and Address of Hospital

Details of surgical treatment, if any.

Date surgery was performed (month/day/year)	Name and address of Surgeon	Type of surgical treatment

4. Patient's Progress

Is patient

☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

Describe briefly the patient's present condition.	Is this condition a sole and direct result of that injury/accident? ☐ Yes ☐ No

What further complications can be expected?

State how long will the patient be disabled.

5. Cardiac (If Applicable)

Functional Capacity (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Blood Pressure (last visit)

Systolic Diastolic

6. Physical Impairment

☐ Class 1 - No limitation of functional capacity, capable of physical activity (0-10%)

☐ Class 2 - Slight limitation of functional capacity, capable of light manual activity (15-30%)

☐ Class 3 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity (35-55%)

☐ Class 4 - Marked limitation (60-70%)

☐ 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)? ☐ Yes ☐ No

Remarks

7. Mental/Nervous Impairment

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitation)

☐ Class 2 - Patient is able to function in most situations and engage in most interpersonal relations (slight limitation)

☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)

☐ Class 4 - Patient is unable to engage in stress situtations or engage in interpersonal relations (marked limitation)

☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)

Remarks

2 Physician or Surgeon's Statement (continued)

8. Prognosis

	Patient's Job	Any Other Work
Is patient now totally incapacitated to resume work?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes", when can trial employment commence?	(month/day/year)	(month/day/year)
	☐ Part-Time ☐ Full-Time	☐ Part-Time ☐ 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

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? ☐ Yes ☐ 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? ☐ Yes ☐ No If "Yes", for what illness or accident and when? (month/day/ year)	Was the patient referred to you by another physician? ☐ Yes ☐ 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? ☐ Yes ☐ No	If so, how?

12. Other Comments/Remarks

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