Attending Physician's Statement
(Critical Condition Rider/Critical Illness Benefit)

Sun Life Financial

Please PRINT clearly.
Use BLACK ink.
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 / Patient Information (To be completed by 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's Statement (To be completed by the Attending Physician)

Date you first attended the patient for the disease (month/day/year)	How long do you believe the symptoms had been present when you were first consulted?
Date the patient was informed of the diagnosis (month/day/year)	Date of surgery, if applicable (month/day/year)

1. Provide full and exact details of diagnosis. If cancer, please specify the stage.

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

3. Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests. Please include dates.)

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

4. Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? ☐ Yes ☐ No

If No, please provide details.

Since when? (month/day/year)	Activities of Daily Living he/she cannot perform:

5. What kind of treatments has the insured received in relation to the condition?

6. Were there other treatments/procedures recommended to the insured? If "Yes", please specify. ☐ Yes ☐ No

7. Did the patient's condition resulted in any major, permanent neurological deficit that will require physical rehabilitation? ☐ Yes ☐ No

Since when (month/day/year)	Expected Recovery (month/day/year)

8. Has the patient been hospitalized or attended to for any other medical condition? ☐ Yes(please provide details) ☐ No

Name and Addresses of Attending Physician	Date of Consultation	Diagnosis

9. Are you the patient's regular attending physician?..... ☐ Yes (please provide details) ☐ No

Period of Consultation	Past Health History

10. Please provide details of physicians to whom the patient had been referred, or who attended to the patient.

11. 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 "Yes", when was the last time the patient smoked a cigaratte/cigarillo/cigar or consumed any other tobacco product on 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

12. If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.

3 Signature

Signature of Attending Physician X	Printed Name

PTR No.	License No.	Field of Specialization

Medical Office Address	
Contact Number/s	Email-Address

Clinic Hours	Date of Signing (month/day/year)	Place of Signing