Attending Physician's Statement
(Accidental Dismemberment & Disablement Benefit)

Sun Life

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 Sun Life of Canada (Philippines), Inc.

This form is applicable to the following benefits: Accidental Dismemberment & Disablement (ADD&D), Accidental Dismemberment Benefit (AX), Accidental Indemnity Benefit (AI), Basic Accident Rider (BAR) and Comprehensive Accident Rider (CAR)

Please PRINT clearly.

1 General Information (to be completed by the patient)

Relating to the Patient

Name (first, middle initial, last)	☐ Male ☐ Female	Date of Birth (day/month/year)
Residence Address (no., street, municipality)		

City	Province	Country	Zip Code
Home Phone Number(s)	Business Phone Number	Cell Phone Number	Email Address
Policyowner (Please complete if policyowner is other than the life insured)			

Authorization:

By signing below, you agree that the Company shall process your personal and sensitive personal information to evaluate, process, and implement the transaction or request that you have initiated. The Company may disclose your personal and sensitive personal information to its affiliates, service providers, and other third parties for processing consistent with the foregoing purpose, and to comply with legal obligations, as well as laws and regulations (domestic or foreign).

Your rights include the right to be informed, access your data, and rectify errors in your data. For more information about your rights and how we protect your data, you may access our privacy policy at https://online.sunlife.com.ph/privacy. Should you have any concerns in relation to your rights or the processing of your personal and sensitive personal information, you may get in touch with our Data Protection Officer at privacyconcern@sunlife.com.

Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent	Date of Signing (day/month/year)

2 Physician or Surgeon's Statement

1. Losses suffered by patient	Date of Loss (day/month/year)	Extent of Loss	Yes	No
☐ sight of one eye ☐ both eyes ☐ hearing of one ear ☐ both ears	_____ _____	Is loss of sight total and irrecoverable? Is loss of hearing total and irrecoverable?	☐	☐
☐ one hand ☐ both hands ☐ one arm ☐ both arms ☐ four fingers and ☐ index finger ☐ thumb of one hand ☐ middle finger ☐ four fingers ☐ ring finger ☐ thumb ☐ little finger ☐ metacarpals of 1st and 3nd (additional) ☐ metcarpals 3rd, 4th or 5th (additional)	_____ _____ _____ _____ _____ _____ _____ _____	Was severance at or above wrist? Was severance at or above elbow? Was severance at or above the metacarpophalangeal joints?	☐ ☐ ☐	☐ ☐ ☐
☐ one foot ☐ both feet ☐ one leg ☐ both legs ☐ all toes on one foot ☐ big toe ☐ any toe other than big toe, each		Was severance at or above ankle? Was severance at or above knee? Was severance at or above the metatarsophalangeal joints?	☐ ☐ ☐	☐ ☐ ☐

If any question under "Extent of Loss" is answered "No", please give details.

2 Physician or Surgeon's Statement (continued)

2. Details of Accident

Date of Accident (day/month/year)	
Did losses or disability occur from bodily injury caused solely by accident? ☐ Yes ☐ No	If no, give details of contributory causes.

3. Details of Treatment

Date of first treatment following accident (day/month/year)	Was the patient treated in any hospital/clinic/institution? ☐ Yes ☐ No

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

Details of surgical treatment, if any.

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

4. Progress

Has Patient	☐ Recovered	☐ Improved	☐ Remained Unchanged	☐ Retrogressed
Is Patient	☐ Ambulatory	☐ House Confined	☐ Bed Confined	☐ Hospital Confined

Describe briefl y 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.	
Has patient been hospital confined? ☐ Yes ☐ No	If yes, please provide name and address of hospital
Date Admitted (Month/Day/Year)	Date Discharged (Month/Day/Year)

5. Cardiac (If Applicable)

Functional Capacity (American Heart Association) ☐ Class 1 (No Limitation)	☐ Class 2 (Slight Limitation)	☐ Class 3 (Marked Limit	☐ Class 4 (Complete Limitation)
Blood Pressure (Last Visit)	Systolic	Diastolic	

6. Physical Impairment

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

2 Physician or Surgeon's Statement (continued)

7. Mental/Nervous Impairment

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most situations and engage in most interpersonal relations (slight limitations)
☐ 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 situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has signifi cant loss of psychological, physiological, personal and social adjustment (severe limitation)

Remarks

8. Neurological Deficits (If Applicable)

Functional Deficit

Involved Area

Severity:
☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

To what extent has recovery occured neurologically? Functionally?
☐ 0% ☐ 20% ☐ 40% ☐ 60% ☐ 100% ☐ 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 defi cits to remain during patient's lifetime? ☐ Yes ☐ No
If "NO", what type of work would patient be capable of performing after recuperation?
☐ Own occupation prior to disability
☐ Other occupation, please specify: _____

9. Prognosis
IS PATIENT CURRENTLY ABLE TO RESUME WORK? (please check appropriate box)
☐ Yes
- If yes, ☐ On own occupation prior to diability?
  ☐ On other occupation
- Since when? (Month/Year) _____

☐ No
- If no, when do you expect patient to recover to resume work? (Month/Year) _____
- Can patient resume own occupation prior to disability?
- If no, what type of occupation can patient perform? Why?

_____
_____

Other Comments/Remarks

2 Physician or Surgeon's Statement (continued)

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 number per day.

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

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?	When did you first see the patient for this injury/condition? (day/month/year)
Did you attend to him/her for any other illness or accident? Yes No If "Yes", for what illness or accident and when? (day/month/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	Date of Signing (day/month/year)

Field of Specialization	License No.	PTR No.

Telephone Number	Mobile Number	E-Mail Address	Fax Number
Address (no., street, municipality)			City
Province	Country		Zip Code