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

Please PRINT clearly.
Use BLACK ink.
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 Sun Life of Canada (Philippines), Inc.

1 Life Insured / Patient Information (To be completed by the patient)

Policy Number/s	
Name (Last Name, First Name, M.I.)	Date of Birth (day/month/year)
Residence Address (no., street, municipality)	
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, 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 (month/day/year)

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

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

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

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

Signature of Attending Physician X		Printed Name	
PTR No.	License No.	Field of Specialization	
Medical Office Address			
Contact Number/s	E-Mail Address		
Clinic Hours	Date of Signing (day/month/year)	Place of Signing	