

Attending Physician's Statement (Child Delivery)



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 the Sun Life of Canada (Philippines), Inc.

1 General Information (to be completed by the patient)

I. Relating to the Patient

Name (Last Name, First Name, M.I.)	Date of Birth (Month/Day/Year)
Residence Address (number, street, municipality)	
Contact Number/s	Email 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 or Surgeon's Statement

1.a. Date of delivery. (month/day/year)	1.b Are you the regular OB-Gynecologist of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give name of doctor who referred the patient to you.
2. Give the <u>names</u> and <u>addresses</u> of other attending doctors of the patient.	
Name	Address
3. Type of delivery (pls. check appropriate box)	
<input type="checkbox"/> Normal delivery	<input type="checkbox"/> Caesarian Section delivery
4. This is the patient's ___ delivery. (pls. check appropriate box)	
<input type="checkbox"/> first	<input type="checkbox"/> second
<input type="checkbox"/> third	<input type="checkbox"/> others, specify
5. Were there any complications during delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details.	



2 Physician or Surgeon's Statement - continued

6. On what date were you first consulted by the patient? (month/day/year)		7. Reason for consultation	
8. Was the patient referred to you by another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide name and address of referring doctor			
9. What health history was disclosed when the patient first consulted you?			
10. Please provide details of the patient's habits in relation to smoking			
Did the insured 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 with number per day			
cigarettes	E-cigarettes	cigars	others
b) If "No", did the life insured ever smoke a cigarette/cigarillo/cigar or consumed any other tobacco product in the past?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?		month/year;	

3 Signature

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