Attending Physician's Statement (Disability)

Sun Life

Please PRINT clearly.
If with erasures,
please countersign.

Please answer all
questions in full.

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 Company.

The purpose of this report is to assist us in making a disability determination. In filling out this report, please include sufficient details of history, physical, and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

1 General Information (to be completed by the patient)

Relating to the Life Insured/Patient

Life Insured (Last Name, First Name, M.I.) ☐ Male ☐ Female			Date of Birth (Month/Day/Year)
Complete Address			Sun Life Policy Number(s)
Home Phone	Business Phone	Cellphone	Email Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month/Day/Year)

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

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

I. History

When did symptoms first appear or when did accident happen? (Month/Day/Year)	When did patient ceasework because of incapacity? (Month/Day/Year)

Did patient previously have the same or similar conditions? ☐Yes ☐No
If "YES", please state when and describe the conditions.

If condition is long standing, how would you describe its evolution since onset?
☐ Improved ☐ Remained the Same ☐ Slight Deterioration ☐ Significant Deterioration

Is condition due to injury or sickness arising from patient's employment?
☐ Yes ☐ No ☐ Unknown

Smoking Habits Question

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	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

Other Attending Physicians

Name of Physician	Address
_____	_____
_____	_____
_____	_____

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

II. Diagnosis (including any complications and stage of illness)

Subjective Symptoms

Objective Findings (Please attach current x-rays, EKG, laboratory tests and any other clinical findings)

III. Dates of Treatment

Date of first Visit (Month/Day/Year)	Date of Latest Visit (Month/Day/Year)
Frequency of Visits ☐Weekly ☐Monthly ☐Others (please specify)	

IV. Nature of Treatment

Please include surgery and medications prescribed, if any. If chemotherapy/radiotherapy,please indicate dates & number of sessions.

V. Progress

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

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

VI. 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	

VII. 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

VIII. 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 significant loss of psychological, physiological, personal and social adjustment (severe limitation)

Remarks

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

IX. Neurological Deficits (If Applicable)

Functional Deficit
Involved Area
Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe
To what extent has recovery occurred 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 deficits toremain 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: _____

X. Prognosis

IS PATIENT CURRENTLY ABLE TO RESUME WORK? (please check appropriate box) ☐ Yes If yes, ☐ On own occupation prior to disability ☐ 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? ☐ Yes ☐ No If no, what type of occupation can patient perform? Why? _____ _____
Other Comments/Remarks

3 Physician's Signature

Signature of Attending Physician X		Printed Name
PTR No.	License No.	Field of Specialization
Clinic Address		Clinic Hours/Schedule
Telephone No.		E-mail Address
Place of Signing		Date of Signing (Month/Day/Year)