Attending Physician's Statement (Living Benefit Rider)

Please PRINT clearly.
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 Life Insured Information (to be completed by the patient)

Relating to the Life Insured/Patient

Name (Last, First, M.I.) ☐ Male ☐ Female	Date of Birth (Month/Day/Year)
Residence Address	
Contact Number/s	Email Address
Policy Number Certificate No.: Individual, specify: Group, specify:	

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 Specific Information Requested (to be completed by the Attending Physician)

Date of First Visit (month/day/year)	Date of Last Visit (month/day/year)	Frequency of Treatments
Initial Date of Diagnosis (month/day/year)	How long have you been attending the patient?	

Names and Addresses of Other Attending Physicians

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

Diagnosis	Present Condition	Prognosis
Predicted Survival Period from date of diagnosis (Life Expectancy)	Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Please Explain ☐ Yes ☐ No	

2 Specific Information Requested (continued)

Attendant/Precipitating/Aggravating conditions:

Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, E.C.G., or any other special tests with dates).

If hospitalized:

Names and Addresses of Hospitals	Dates Confined (month/day/year)	Other Attending Physicians
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How long have you been in active practice?	Are you related to the patient by blood or by affinity? ☐ Yes ☐ No	If so, how?

3 Signature

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