# Attending Physician's Statement
## (Supplementary Statement on 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**<br>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).<br>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<br><br>Date of Signing (month/day/year) |

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

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

| | |
|---|---|
| Diagnosis | Date of Last Examination (Month/Day/Year) |
| Subjective Symptoms | |
| Objective Findings (Please attach current x-rays, EKG, laboratory test and any other clinical findings) | |

II. 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) |

III. Nature of Treatment

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

IV. 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 |
| Date Confined (Month/Day/Year) | Date Discharged (Month/Day/Year) |

V. 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 |

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

VI. 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

VII. 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

VIII. 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 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: _____

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<br>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) |