Attending Physician's Statement (Supplementary Statement on Disability)

Sun Life Financial

Please PRINT clearly.
Please answer all questions in full.
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 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
By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs.
If you need more information about our privacy policy, please visit https://apps.sunlife.com.ph/privacy.

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)

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

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

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

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: _____

IX. 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?

_____

_____

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)