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 Sun Life of Canada (Philippines), Inc.

1 Life Insured Information (to be completed by the patient)

Relating to the Person Insured/Patient

Name (Last, First, M.I.)	☐ Male ☐ Female	Date of Birth (month/day/year)
Residence Address		
Contact Number/s		E-mail Address
Policy Number ☐ Group, specify:	Certificate No.:	☐ Individual, specify:

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 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)	