Attending Physician's Statement (Hospital Income Benefit)

Please PRINT clearly.
If with erasures, please countersign.

In this form, *"you"* and *"your"* refer to the policyowner, 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 General Information (to be completed by the patient)

I. Relating to the Life Insured/Patient

Policy Number/s		
Name (Last, First, M.I.)	☐ Male ☐ Female	Date of Birth (month/day/year)
Residence Address		
Contact Number/s		E-mail Address
Policyowner (Last name, First name, M.I.) (Please complete if policyowner is other than the life insured)		

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. History

a. History of illness and concurrent conditions requiring hospitalization.

b. Was such hospital confinement necessary to the treatment? ☐ Yes ☐ No If "No", please explain why not.

c. Was patient given the option to be admitted? ☐ Yes ☐ No

d. If hospital confinement was not necessary, did patient insist on being admitted? ☐ Yes ☐ No If "No", who recommended that the patient be hospitalized?

e. Date patient first consulted you for this condition or symptoms (month/day/year)

f. When did symptoms of present illness first appear? (month/day/year)

g. Has patient ever had same or similar condition? Describe condition. ☐ Yes ☐ No If "Yes", state when. (month/day/year)

h. Any other illness or impairments to your knowledge? ☐ Yes ☐ No If "Yes", what are these?

i. If hospitalization was due to an accident, when did the accident happen? (month/day/ year) How did it happen?

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

j. 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	others

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 he/she smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?

month/year

k. Names and addresses of other attending physicians.

Name and address of Physician

II. Diagnosis

a. Provide full and exact details of the diagnosis.

b. Nature of Treatment (including surgery, medications prescribed, if any).

c. For this type of illness or injury, what is the usual expected number of days of hospital confinement?

Was period of hospital confinement longer than necessary? ☐Yes ☐No

If "Yes", give reason for prolonged confinement.

III. Additional Information

a. Have you received other requests for completion of forms similar to this one for this condition or accident? ☐Yes ☐No If yes, please provide details.

b. Are you the patient's regular physician? ☐Yes ☐No

How long have you known the patient?

Are you related to the patient by blood or by affinity? ☐ Yes ☐ No

If so, how?

c. Have you attended to the patient for any other illness or injury? ☐ Yes ☐ No

If "Yes", for what illness or injury?

When did you attend to this patient? (month/day/year)

IV. Dates of Hospital Confinement:

Date of Admission (month/day/year)	Date of Discharge (month/day/year)
Name and Address of Hospital	Telephone Number(s)

During the time the patient was hospitalized, was the patient also confined in the Intensive Care Unit? ☐ Yes ☐ No

If "Yes", please state inclusive dates of I.C.U. confinement.

From (month/day/year) to (month/day/year)

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

V. Remarks: Please provide comments and further details which you feel would be helpful.

3 Signatures

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