# Attending Physician's Statement (Disability)

Sun Life Financial

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 the Company.

Please answer all questions in full.

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. History

| When did symptoms first appear or when did accident happen? (Month/Day/Year) | When did patient cease work because of incapacity? (Month/Day/Year) |
|---|---|

Did patient previously have the same or similar conditions? ☐ Yes ☐ No
If "YES", please state when and describe the conditions.

If condition is long standing, how would you describe its evolution since onset?
☐ Improved ☐ Remained the Same ☐ Slight Deterioration ☐ Significant Deterioration

Is condition due to injury or sickness arising from patient's employment?
☐ Yes ☐ No ☐ Unknown

### 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 quantity per day

| cigarettes | E-cigarettes | cigars | others |
|---|---|---|---|
| | | | |

b) If "No", has patient ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... ☐ Yes ☐ No

If "Yes", when did the insured stop smoking? month/year

### Other Attending Physicians

| Name of Physician | Address |
|---|---|
| | |
| | |
| | |

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

### II. Diagnosis (including any complications and stage of illness)

Subjective Symptoms

Objective Findings (Please attach current x-rays, EKG, laboratory tests and any other clinical findings)

### III. 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) | |

### IV. Nature of Treatment

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

### V. 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) | |

### VI. 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 | |

### VII. 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

### VIII. 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

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

### IX. 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) |