

Attending Physician's Statement (SUN Fit and Well)



In this form, "you" and "your" refer to the life insured and policy owner 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.

PRINT clearly. Use BLACK ink. Indicate N/A if question is not applicable. If with erasures, please countersign.

1 Life Insured

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

Data Privacy and Authorization

Medical Information Database

In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph

Authorization to Process Your Personal Data

You understand and acknowledge that the Company, its employees, duly authorized representatives, related companies, third party service providers and vendors, shall use, process and share your information, including sensitive personal information, with any person or organization to (i) administer and service this insurance or investment account; (ii) process claims and enforce/fulfill contractual rights/obligations; or (iii) for other reasonable purposes related to the provision of products and services (including but not limited to improvement/upgrade in systems and business processes, data analytics, automated processing, etc.).

The Company may further process your information for purposes of complying with its legal obligations, laws and regulations (including but not limited to the Anti Money Laundering Act and Credit Information Systems Act); pursue its legitimate and lawful rights and interests; and other purposes allowed under privacy laws and regulations.

Your personal data shall be retained throughout the duration of your coverage under your plan or existence of your account(s) and/or until expiration of the retention limit set by laws and regulations from account closure and the period set for destruction or disposal of records. You certify that you have read, understood and agree with the declarations and authorizations above, including Sun Life's privacy policy found in <https://apps.sunlife.com.ph/privacy>.

Would you like to receive personalized communications, products, and service offers from the Company, Sun Life Asset Management Company, Inc. (SLAMCI) and related parties that may help with your financial needs? Yes No

Signature of Patient (or Parent, if minor)	Printed Name of Patient/ Parent X
Date of Signing (month/day/year)	Place of Signing



2 Physician's Statement

This claim is for: (Please choose from the list of benefits below)

Group	Minor Critical Illness	Major Critical Illness
Heart Related	<input type="checkbox"/> Cardiac Defibrillator <input type="checkbox"/> Cardiac Pacemaker Insertion <input type="checkbox"/> Angioplasty and other Invasive Treatment for Coronary Artery Disease <input type="checkbox"/> first Angioplasty <input type="checkbox"/> with previous Angioplasty <i>Please specify the date (month/day/year)_____</i>	<input type="checkbox"/> Acute Heart Attack <input type="checkbox"/> Coronary Artery Bypass Surgery <input type="checkbox"/> Dissecting Aortic Aneurysm <input type="checkbox"/> Replacement of Heart Valve <input type="checkbox"/> Surgery for Disease of the Aorta (Aorta Surgery) <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Eisenmenger's Syndrome <input type="checkbox"/> Idiopathic Pulmonary Arterial Hypertension <input type="checkbox"/> Severe Infective Endocarditis
Cancer Related	<input type="checkbox"/> Carcinoma-in-situ of the following sites: breast, uterus, fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, stomach, or nasopharynx <input type="checkbox"/> Early Prostate Cancer <input type="checkbox"/> Early Thyroid Cancer <input type="checkbox"/> Early Bladder Cancer <input type="checkbox"/> Early Ovarian Cancer <input type="checkbox"/> Early Chronic Lymphocytic	<input type="checkbox"/> Invasive Cancer <input type="checkbox"/> Cerebral Metastasis
Liver Related		<input type="checkbox"/> End Stage Liver Failure <input type="checkbox"/> Fulminant Hepatitis
Kidney Related	<input type="checkbox"/> Surgical Removal of One Kidney <input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Medullary Cystic Disease <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis
Lung Related	<input type="checkbox"/> Insertion of a Vena-Caval Filter	<input type="checkbox"/> End Stage Lung Disease
Neurological Related	<input type="checkbox"/> Cerebral Shunt Insertion <input type="checkbox"/> Cerebral Aneurysm Surgery <input type="checkbox"/> Moderately Severe Alzheimer's Disease <input type="checkbox"/> Moderately Severe Parkinson's Disease	<input type="checkbox"/> Stroke <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/> Progressive Bulbar Palsy (PBP) <input type="checkbox"/> Progressive Muscular Atrophy (PMA) <input type="checkbox"/> Progressive Supranuclear Palsy <input type="checkbox"/> Guillain-Barre Syndrome <input type="checkbox"/> Motor Neuron Disease (MND) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Bacterial Meningitis <input type="checkbox"/> Benign Brain Tumor <input type="checkbox"/> Coma <input type="checkbox"/> Major Head Trauma <input type="checkbox"/> Brain Surgery <input type="checkbox"/> Meningeal Tuberculosis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Apallic Syndrome <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Creutzfeldt-Jacob Disease <input type="checkbox"/> Severe Myasthenia Gravis <input type="checkbox"/> Paralysis <input type="checkbox"/> Hemiplegia
Gastrointestinal Related		<input type="checkbox"/> Severe Crohn's <input type="checkbox"/> Severe Ulcerative Colitis <input type="checkbox"/> Acute Necrohemorrhagic Pancreatitis <input type="checkbox"/> Chronic Relapsing Pancreatitis
Blood Related		<input type="checkbox"/> Aplastic Anaemia <input type="checkbox"/> Occupational Acquired HIV
Others		<input type="checkbox"/> Deafness <input type="checkbox"/> Loss of Limbs <input type="checkbox"/> Total Blindness <input type="checkbox"/> Loss of Speech <input type="checkbox"/> Major Burns <input type="checkbox"/> Major Organ Transplant <input type="checkbox"/> Terminal Illness <input type="checkbox"/> Amputation due to Diabetic Complication <input type="checkbox"/> Elephantiasis <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Severe Rheumatoid Arthritis <input type="checkbox"/> Ebola <input type="checkbox"/> Surgery for Idiopathic Scoliosis

2 Physician's Statement (cont.)

Others		<input type="checkbox"/> Necrotizing Fasciitis <input type="checkbox"/> Loss of Independent Existence <input type="checkbox"/> Chronic Adrenal Sufficiency <input type="checkbox"/> Progressive Scleroderma <input type="checkbox"/> Pheochromocytoma
Child Conditions	<input type="checkbox"/> Dengue Hemorrhagic Fever (Grades III and IV) <input type="checkbox"/> Hemophilia A and Hemophilia B <input type="checkbox"/> Insulin Dependent Diabetes Mellitus <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Osteogenesis Imperfecta <input type="checkbox"/> Rheumatic Fever with Valvular Impairment	

Date when you first attended the patient for the disease (month/day/year)	How long do you believe the symptoms had been present when you were first consulted?
Date the patient was informed of the diagnosis (month/day/year)	Date of surgery, if applicable (month/day/year)

Dates of Hospital Confinement:

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

Provide full and exact details of diagnosis. Please specify the stage or classification in the box provided below.

Please describe the underlying cause of the patient's condition. And if surgery was done, please provide the reason in the box provided below.

Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests. Please include dates.

Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", state when. (month/day/year) _____ Describe condition.
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What kind of treatments has the insured received in relation to the condition? Please provide the answer in the box provided below.

Can the patient's condition still be resolved by medication/treatment/surgery? Yes No Please explain in the box provided below.

Were there other treatments/procedures recommended to the insured? If "Yes", please specify in the box provided below. Yes No

Did the patient's condition result in any major, permanent neurological deficit that will require physical rehabilitation? Yes No

Since when (month/day/year)	Expected Recovery (month/day/year)
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2 Physician's Statement (cont.)

Is the patient capable of performing activities of daily living? Yes No

If no, what activities of daily living is the patient unable to perform?

Activities of Daily Living	Since when (month/ day/ year)	Expected Recovery (month/ day/ year)
washing/ bathing		
dressing		
transferring		
toileting/ using the lavatory		
feeding		
mobility		

If yes, did the patient experience inability to perform the activities of daily living?

No

Yes. Please answer the table below.

Activities of Daily Living	Start date (month/ day/ year)	Recovery date (month/ day/ year)
washing/ bathing		
dressing		
transferring		
toileting/ using the lavatory		
feeding		
mobility		

Prognosis	Present Condition	Predicted Survival Period from date of diagnosis (Life Expectancy)

Has the patient patient been hospitalized or attended to for any other medical condition? Yes No Please provide details.

Name and Addresses of Attending Physician	Date of Consultation	Diagnosis

Are you the patient's regular attending physician? Yes No Please provide details.

Period of Consultation	Past Health History

2 Physician's Statement (cont.)

Please provide details of physicians to whom the patient had been referred, or who attended the patient.

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For Deafness, Total Blindness and Loss of Speech: Is the condition total and irrecoverable? Yes No

If "No", please provide details on the box provided below.

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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", did the patient ever smoke a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... Yes No

If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product

month/year

If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.

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3 Signature

Signature of Attending Physician X		Printed Name	
PTR No.	License No.	Field of Specialization	

Medical Office Address		
Contact Number/s		E-mail Address
Clinic Hours	Date of Signing (month/ day/ year)	Place of Signing