Note: This section must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the Claimant.

1. PATIENT'S INFORMATION

a. Name : _____
Last Name First Name Middle Name

b. Address : _____

c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. CONSULTATION FOR CURRENT ILLNESS OR INJURY/IES

a. Date of first consultation _____

Patient's Complaint(s) _____

b. Symptoms experienced _____ Date symptoms first experienced _____

c. Who is the source of this information? _____

d. Name and Address of Hospital

_____

_____

e. Please provide brief history of patient's illness

_____

_____

f. If Surgical Procedure was performed, please narrate in detail the procedure(s) and provide a copy of the Operation Room Record and Pathology Report .

_____

_____

g. Is the Terminal Illness in the presence of Human Immunodeficiency Virus (HIV) Infection? _____

If yes, please provide date of diagnosis for HIV and copy of the HIV blood test result(s), if any. _____

h. If the condition was a result of an accident, please provide the following information:

Date of accident _____

Please describe the injuries sustained by the patient.

_____

i. Date of Diagnosis _____ Date patient was informed of the diagnosis _____

j. Date when patient was informed that the illness/condition was terminal _____

k. Final Diagnosis/ses _____

l. What is the expected impact on the patient's survival? _____

i. In your opinion, how long is the life expectancy of the patient? _____ months.

ii. Is the patient's condition incurable and beyond any hope of recovery? ☐ Yes ☐ No

iii. Is the advent of death highly probable within 6 months from the date of diagnosis? ☐ Yes ☐ No

iv. Is death highly probable within 12 months from the date of diagnosis? ☐ Yes ☐ No

v. Is the patient currently an in-patient in a hospital, nursing home or hospice? ☐ Yes ☐ No

3. PATIENT'S CONDITION

a. Please describe fully the nature and severity of the patient's current condition.

_____

b. Please describe the past and current treatment/s provided, including any operations performed and whether these are likely to improve patient's condition.

_____

_____

c. Is the patient compliant with the recommended treatment program? _____

If No, please elaborate _____

d. What, if any, are other or further treatments recommended to be performed in the future?

_____

e. How often must the patient be on follow-up consultation/treatments for his/her condition? _____

4. MEDICAL HISTORY

a. Did the patient previously suffer from any related illness(es) that caused the present condition? _____ If Yes, please provide details:

_____

_____

b, Does the patient have family history for this condition? _____ If Yes, please provide information, such as relationship to insured, nature of illness, date of diagnosis/ses and source of information

_____

_____

c . Did the patient consult other doctors for this illness or its symptoms before he/she consulted you? If Yes, please provide the following information:

Date of Attendance	Name of Physician	Medical Institution and Address	Diagnosis/Treatment/ Procedure

d. Is the patient suffering or has suffered from any other significant illnesses? _____ If Yes, please provide details.

_____

_____

e. Please give any other information, which you feel would be helpful in the assessment of the patient's claim.

_____

_____

NOTE: Please enclose copies of specialist or hospital reports together with any tests or similar evidence in your possession to support the validity of the patient's claim.

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____20_____.

_____
Signature Over Printed Name
of Physician

_____
Specialty

_____
Address

_____
Contact Number (s)

_____
PRC Number

_____
PTR Number