Sun Life GREPA Financial

Attending Physician's Statement (Hospitalization Benefit)

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 Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco Group of Companies.

The patient is responsible for the completion of this form without expense to Sun Life Grepa Financial, Inc.

This form is applicable to the following hospitalization benefits: Hospital Income Benefit (HIB), Hospital Surgical Benefit (HSB), Intensive Care Unit Benefit (ICU), Daily Hospital Income Benefit (DHI) and Health Plan (HP).

Please PRINT Clearly.

1 General Information (to be completed by the patient)

I. Relating to the Life Insured/Patient

Name (last, first, middle) ☐ Male ☐ Female			Date of Birth (day/month/year)
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)
Cell Phone Number	Business Phone Number	E-mail Address	Sun Life Policy Number(s)
Policyowner (lastname, firstname, 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://www.sunlifegrepa.com/LegalPrivacySecurity.aspx.

Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent	Date of Signing (day/month/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. (day/month/year)	f. When did symptoms of present illness first appear? (day/month/year)

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

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

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? (day/month/year)
How did it happen?

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 number per day

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

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. Describe nature of illness or injury.

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.

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

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? (day/month/year)

IV. Dates of Hospital Confinement:

From (day/month/year) To (day/month/year)		Name of Hospital	
Address		City	
Province	Country	Zip Code	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 (day/month/year) to (day/month/year)

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	
Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)
Cell Phone Number	Business Phone Number	Fax Number	E-mail Address
Place of Signing			Date of Signing (day/month/year)