Sun Life GREPA Financial

Living Benefit Attending Physician's Statement

In this form, *you* and *your* refer to the physician who attended to the patient, while *we*, *us*, *our* and the *Company* refer to Sun Life Grepa Financial, Inc. (SLGFI), a joint venture of Sun Life and the Yuchengco Group of Companies.

Sections 1-3 are required. For Sections 4 and onwards, please answer only the questions applicable to the patient's case.

1 Information about the Patient

Name of Patient (Last Name, First Name, M.I.)	Date of Birth (month/day/year)

2 Details of Condition

Date symptoms and signs were first experienced and noticed by the patient (month/day/year)	Symptoms experienced and signs noticed
Date you first attended to the patient (month/day/year)	Reason for consultation

Was the patient attended by any other physician/specialist for these symptoms and signs before and after he/she consulted you?
Yes ☐ No ☐ If "Yes", please provide the details below:

Name of Physician/Specialist (e.g. MD, ROT, LPT)	Name of Hospital/Medical Facility	Date Attended (month/day/year)

If the space is insufficient, use the back page of this form.

Diagnosis (if applicable, please indicate the stage)	ICD Code
Medical tests/procedures performed supporting the diagnosis (Please include the dates)	
Was the patient or his/her next of kin informed of the above diagnosis? Yes ☐ No ☐ If "Yes", please provide the date (month/day/year) _______________	

Was the patient hospitalized for this condition? Yes ☐ No ☐ If "Yes", please provide the details below:

Date of Admission (month/day/year)	Date of Discharge (month/day/year)
Name and address of hospital	

Was the patient transferred to another hospital/facility for further test/procedure? Yes ☐ No ☐ If "Yes", please provide the details below:

Date of Admission (month/day/year)	Date of Discharge (month/day/year)
Name and address of hospital	

3 Details of Treatment/Consultation

List all the dates when the patient consulted and was treated.

Date of Consultation/ Treatment (month/day/year)	Vital Signs (Blood Pressure, Temperature, etc.)	Symptoms Experienced and Signs Noticed	Date Symptoms and Signs First Noticed (month/day/year)	Diagnosis/Remarks	Medication Prescribed and Other Treatment Modalities

If the space is insufficient, use the back page of this form.

What medical history was disclosed to you by the patient?

Diagnosis/Illness (Please enumerate all)	Date of Diagnosis/Illness	Name of Attending Physician/ Specialist	Name of Hospital/Clinic	Medication Prescribed and Other Treatment Modalities

If the space is insufficient, use the back page of this form.

Smoking Habit

To your knowledge, did the patient smoke? Yes ☐ No ☐ If "Yes", please provide details below:

Start date (month/day/year): ______________________________ End date (month/day/year): ______________________________

Source of information: ______________________________ Relationship (other than the patient): ______________________________

4 Neurological-related questions

Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? Yes ☐ No ☐

If "No", please provide details.

Activities of Daily Living			Since when (month/day/year)	Expected Recovery (month/day/year)
Washing/bathing	☐ With assistance	☐ Without assistance		
Dressing	☐ With assistance	☐ Without assistance		
Transferring	☐ With assistance	☐ Without assistance		
Toileting	☐ With assistance	☐ Without assistance		
Feeding	☐ With assistance	☐ Without assistance		
Mobility	☐ With assistance	☐ Without assistance		

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

If "Yes", please provide details.

Neurological Deficit	Severity (Mild, Moderate, Severe)	Start Date (month/day/year)	End Date (month/day/year)	Date of Expected Recovery if deficit still persists (month/day/year)

Glasgow Coma Score for seven (7) consecutive days

Date (month/day/year)	Glasgow Coma Score

For Severe Myasthenia Gravis, please provide full details of diagnosis using appropriate clinical classification.

5 Other Conditions

If the diagnosis is **Deafness**, is the loss of hearing in both ears total and irreversible? ☐ Yes ☐ No

If the diagnosis is **Blindness**, is the loss of all vision in both eyes total permanent and irrecoverable? ☐ Yes ☐ No

If the diagnosis is **Loss of Speech**, is the loss of the ability to speak total and irrecoverable? ☐ Yes ☐ No

If the diagnosis is **Elephantiasis**, is the lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities? ☐ Yes ☐ No

If the patient was diagnosed with a **Terminal Illness**, what is the predicted survival period from date of diagnosis (life expectancy)? ____________________

6 Disability-related questions

When did patient cease to work because of incapacity? (month/day/year) ______________________________

How would you describe the patient's condition since onset of disability?

☐ Improved ☐ Remained the same ☐ Slight deterioration ☐ Significant deterioration

How would you describe the current physical, cardiac and mental/nervous impairment of the patient?

Class	Physical Impairment	Cardiac Functional Classification (NYHA Classification)	Mental/Nervous Impairment
1	☐ No limitation, capable of physical activities (1-10%)	☐ No limitation; ordinary physical activity does not cause undue fatigue, palpitation or shortness of breath	☐ Patient is able to function under stress and engage in interpersonal relations.
2	☐ Slight limitation, capable of light manual activities (15-30%)	☐ Slight limitation; Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, shortness of breath or chest pain.	☐ Patient is able to function in most situations and engage in most interpersonal relations.
3	☐ Moderate limitation, capable of clerical/ administrative (sedentary) activities (35-55%)	☐ Marked limitation; Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, shortness of breath or chest pain.	☐ Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations.
4	☐ Marked limitation (60-70%)	☐ Complete limitation; Symptoms of heart failure at rest. Any physical activity causes further discomfort.	☐ Patient is unable to engage in stressed situations or engage in interpersonal relations.
5	☐ Severe limitation, incapable of minimal activities (75-100%)		☐ Patient has significant loss of psychological, physiological, personal and social adjustment.

Is patient currently able to resume work?

☐ Yes

- ☐ On own occupation, since (month/day/year) ________________________________
- ☐ On other occupation, since (month/day/year) ________________________________

☐ No

When do you expect patient to recover to resume work? (month/day/year) ________________________________

What type of occupation can patient perform? Why?

7 Physician's Signature

Please complete all the fields below:

Signature of Physician X	Printed Full Name
Field of Specialization	Date (month/day/year) and Place Signed
Address	Clinic Hours
Contact Number	E-mail Address
PTR No.	License No.