

## ATTENDING PHYSICIAN'S STATEMENT – ACCIDENTAL DISMEMBERMENT OR DISABILITY CLAIM

Note: Kindly submit this form to InLife Benefits Insurance Company, Inc duly completed by a qualified and registered physician at the expense of the claimant.

### PATIENT'S DETAILS

Last Name		First Name		Middle Name	
Address					
Date of Birth (MM/DD/YYYY)	Place of Birth			Age	Status
Date of Death	Place of Death				
How long have you known the patient?					
When did the patient first consult you for the injury?					
What was the cause of the patient's injury? Please describe in detail.					
What is your final diagnosis					
If Surgical Procedure was performed, please describe in detail and provide copy of the Operation Room Record.					
Please classify his disability: <input type="radio"/> Total Permanent <input type="radio"/> Partial Permanent <input type="radio"/> Total Temporary <input type="radio"/> Partial Temporary					
If partially disabled, what is the degree of incapacity?					

**IF CLAIM IS DUE TO DISABILITY BENEFIT**

Is the patient able to perform any and every duty of his own occupation? <input type="radio"/> Yes <input type="checkbox"/> No
If yes, when is he/she expected to return to his/her usual occupation?
If no, when did he/she cease all work. <span style="float: right;"><input type="checkbox"/> Yes    <input checked="" type="radio"/> No</span>
In your opinion, is the patient totally and permanently disabled and unable to engage in any occupation or perform any work for income or profit currently or at anytime thereafter.

**IF CLAIM IS DUE TO DEATH BENEFIT**

Cause of Death Immediate Cause
Antecedent Cause
Underlying Cause
Other significant factors contributing to death

PLEASE GIVE DETAILS OF THE PATIENT'S PREVIOUS CONDITIONS FOR WHICH YOU ATTENDED PRIOR TO LAST ILLNESS/INJURY:

Date of Attendance	Diagnosis	Treatment/Procedure

Did you personally see the remains of the deceased?  Yes  No

Was there an autopsy or any other post-mortem examination made on the body of the deceased?  Yes  No

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I **HEREBY CERTIFY** that the above statements are true and complete to the best of my knowledge and belief.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME OF PHYSICIAN

\_\_\_\_\_  
QUALIFICATION

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CONTACT DETAILS

SUBSCRIBED AND SWORN to me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ by the above claimant who exhibited to me his/her Residence Certificate No. \_\_\_\_\_ issued at \_\_\_\_\_ on \_\_\_\_\_.

Doc. No. \_\_\_\_\_ Book No. \_\_\_\_\_

Page No. \_\_\_\_\_ Series of \_\_\_\_\_

My Commission expires on \_\_\_\_\_

NOTARY PUBLIC