

ATTENDING PHYSICIAN'S STATEMENT – ACCIDENTAL MEDICAL REIMBURSEMENT

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		
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.					
If Surgical Procedure was performed, please describe in detail and provide copy of the Operation Room Record.					

DETAILS OF HOSPITAL ADMISSION

Date admitted in the hospital	Date of Discharge	No. of Days
Final Diagnosis		
Date of diagnosis	What are the medications given and laboratory examinations requested?	
When is the patient expected to return to work?		

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

Date of Attendance	Diagnosis	Treatment/Procedure

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



formerly Generali Life Assurance
Philippines, Inc.

InLife Benefits Insurance Company, Inc.
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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

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