



formerly Generali Life Assurance Philippines, Inc.

InLife Benefits Insurance Company, Inc.
10th Floor Petron Mega Plaza, Makati City Philippines 1209
P +632 8888 0808 | TIN 203-028-895-000
inlifebenefits.com.ph

ATTENDING PHYSICIAN'S STATEMENT – 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

Form with fields for Patient's Details including Last Name, First Name, Middle Name, Address, Date of Birth, Place of Birth, Age, Status, and various medical history questions.

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

Table with 3 columns: Date of Attendance, Diagnosis, Treatment/Procedure

ARE YOU AWARE OF ANY OTHER CONSULTATION OR CONFINEMENT OF THE PATIENT FOR ANY ILLNESS OR INJURY, IF SO PLEASE PROVIDE INFORMATION BELOW:

Table with 4 columns: Date of Attendance, Name of Physician/Address, Medical Institution/Address, 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.



Benefits

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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 OF PHYSICIAN

QUALIFICATION

ADDRESS

CONTACT DETAILS

SUBSCRIBED AND SWORN to me this _____ day of _____, 20_____ by the aboce 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