



formerly Generali Life Assurance Philippines, Inc.

InLife Benefits Insurance Company, Inc.
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ATTENDING PHYSICIAN'S STATEMENT – HOSPITAL INCOME BENEFIT

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: 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 present condition?, Please state the date symptoms were noticed and describe in detail

DETAILS OF HOSPITAL ADMISSION

Form with fields: Date admitted in the hospital, Date of Discharge, No. of Days, Final Diagnosis, Date of diagnosis, What is the prognosis?, 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:

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

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 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