

ATTENDING PHYSICIAN'S STATEMENT – TERMINAL ILLNESS

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 present condition?					
Please state the date symptoms were noticed and describe in detail.					
Who is the source of this information?					

DETAILS OF TERMINAL ILLNESS

What is the diagnosis and exact condition causing the terminal illness?	
If Surgical Procedure was performed, please provide in detail and provide copy of the Operation Room Record.	
Date of diagnosis	What is the prognosis?
In your opinion, how long is the life expectancy of the patient? _____ months	
Please provide in detail the medical evidence to support your opinion	
What is the current symptom/s and treatment/s and its impact on the patient's survival?	

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

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:

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.



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

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



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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 _____.

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