InLife Benefits
formerly Generali Life Assurance Philippines, Inc.

InLife Benefits Insurance Company, Inc.
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ATTENDING PHYSICIAN'S STATEMENT – DREAD DISEASE CLAIM

Note: Kindly submit this form to Inlife Benefits Insurance Company, Inc. (INLIFE BENEFITS) 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

TYPE OF CLAIM

State the nature of Dread Disease the patient is claiming for:

	Cancer		Cardiomyopathy		Muscular Dystrophy
	Cerebrovascular Stroke		Coma		Paralysis
	Coronary Artery Bypass Surgery		Encephalitis		Parkinson's Disease
	Heart Attack		Fulminant Viral Hepatitis		Poliomyelitis
	Kidney Failure		Heart Valve Replacement		Primary Pulmonary Arterial Hypertension
	Liver Cirrhosis		Loss of Hearing		Progressive Bulbar Palsy
	Vital Organ Transplant		Loss of Limbs		Progressive Muscular Atrophy
	Alzheimer's Disease		Loss of Sight		Severe Brain Damage
	Amyotrophic Lateral Sclerosis		Loss of Speech		Surgery to Aorta
	Aplastic Anemia		Major Burns		Terminal Illness
	Bacterial Meningitis		Motor Neuron Disease		Total and Permanent Disability
	Benign Brain Tumor		Multiple Sclerosis		

How long have you known the patient?	When did the patient first consult you?
Please state the date symptoms were noticed?	Describe in details
Please provide complete diagnosis of patient's condition.	
If surgical procedure was performed, please describe in detail and provide copy of the Operation Room Record.	
Please classify the disability of the patient? Partial and Temporary? _____ Total and Temporary? _____ Partial and Permanent?_____ Total and Permanent? _____	
Please provide full details of the capabilities and limitations of the patient.	
Capabilities (What the patient can do)	Limitation (What the patient cannot do)

Please state the diagnostic procedures done:

Type of Test	Date of Test	Result

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

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