PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT- Cancer/Terminal or Other Illnesses

Name of the Patient (Last name, First name, Middle name)	**Date of Birth**

The above person is insured with Pru Life Insurance Corporation of U.K. against the happening of certain contingent events associated with their health. A claim has been submitted in connection with their insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form

In order for the claim to be valid the following definition must be fulfilled :

***Cancer*. This means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukemia but excludes non-invasive cancers in situ, tumors in the presence of any Human Immuno-deficiency Virus and any skin cancer other than malignant melanoma.**

A. General

QUESTIONS	YES	NO	**Please give Details To "YES" Answers**
1. Are you the patient's usual attending physician? If yes, over what period do your records extend?	☐	☐	
2. When were you first consulted for this condition, and at that time, how long had symptoms been present?			
3. Has the patient previously suffered from the condition specified above or any possible related illness? If yes, please give dates of consultations and resulting diagnosis below.	☐	☐	

Date of Consultation	Name of Physician	Hospital/Clinic	Diagnosis	Treatment

4. On which date did the patient become aware of the condition?	

B. Medical Details if Illness is <u>Cancer</u> (Write "NA" if question/s is/are not applicable).

1. Please provide dates with full and exact details of the diagnosis.	
2. What was the site or organ involved and the precise histology of the tumor ?	
3. What stage did the disease reach? Please describe using whichever staging classification is appropriate.	
4. Was the disease completely localized?	
5. Was there an invasion of adjacent tissues?	
6. Were regional lymph nodes involved?	
7. Was there distant metastasis?	
8. Is there anything in the patient's family history which would have increased the risk of cancer? Please describe.	
9. If the diagnosis is Leukemia, please provide details of the actual type.	

NAME OF THE PATIENT: ____________________
Last Name, First Name, Middle Name

9. In your opinion, does the condition suffered by your patient fulfill the definition of cancer stated above or overleaf this page?	
10. What is the prognosis of the patient's condition?	
11. In your opinion, would you classify the present illness as terminal? If so, what is the life expectancy?	

C. Other details on Illness/es if not covered in Section B (non-cancer)

1. Please provide dates with full and exact details of the diagnosis.	
2. Did the patient undergo surgery? Please indicate the procedure performed.	
3. In cases of Parkinson's Disease, can you describe the specific condition or conditions of which the illness has affected the patient?	
4. Would the illness permanently prevent the patient from performing activities of daily living without assistance? Please describe these activities the patient is unable to do.	
5. What is/are the predisposing factor/s contributory to the illness of the patient? Please give exact details on the history of such illness.	
6. What is the prognosis of the patient's condition?	
7. Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition.	
Name of Physician	**Address**

DECLARATION
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION
I further authorize the medical director of Pru Life Insurance Corporation of U.K. or any of its authorized representatives or other person in its employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

PURPOSE STATEMENT
We will process the information you have provided in this form for the purpose of handling your patient's request in accordance with applicable privacy laws and regulations. During processing, we may share the information you provided to our authorized data processors, including couriers and contractors for anti-money laundering systems, photocopying, scanning, indexing and printing services. We may share any information provided with governmental and other regulatory authorities, or self-regulatory bodies in various jurisdictions as required or allowed by applicable laws and regulations. Any information collected may be retained by Pru Life UK and our authorized data processors until ten (10) years from the date of termination of the policy.

You may revisit our privacy policy through our website at (https://www.prulifeuk.com.ph/en/footer/privacy-policy/). For data privacy concerns, please contact our Data Privacy Officer at:Telephone: (632) 8887 5433 for Metro Manila, 1 800 10 7785465 via PLDT landline for domestic toll-free Email: dpo@prulifeuk.com.ph

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Signature Over Printed Name of the Attending Physician

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Specialization

____
Date

Address : ____________________
License No: ____________________