PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - Disability Claim

* Instruction : To be accomplished by each attending physician

The person whose name appears below 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.

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

Address

# Street					
City/Province		Zip Code		Tel #	

Date of Diagnosis / Accident	**Final Diagnosis**	**Date of Admission**	**Date of Discharge**

A. General

Questions	YES	NO	Please give Details To "YES" Answers
1. Are you the patient's regular physician? How long have they been under your care ?	☐	☐	
2. Please describe fully the illness/injury and its severity.			
3. How would you classify the disability? Partial Permanent, Total Permanent, Partial Total Temporary or Partial Temporary?			
4. Please give the direct cause of the disability.			
5. Please indicate approximate date from which the patient first notice symptoms of current condition.			
6. Has the patient been treated previously for this condition? If 'Yes', please state when.	☐	☐	
7. Duration of Illness/Disability. If duration for recovery is more than usual, please explain why.			
8. What is your prognosis?			
9. Is consultation/treatment in connection with this disability related or due to (please indicate date injury/illness was sustained) :			
a. Pregnancy, infertility, sub-fertility or childbirth, abortion? If for pregnancy, what was the approximate date of commencement?	☐	☐	
b. Self-inflicted injury or sexually transmitted disease? If 'Yes', please specify.	☐	☐	
c. Congenital anomaly, nervous or mental disorder? If 'Yes', please specify.	☐	☐	
d. Surgery for cosmetic or aesthetic purposes ? If 'Yes', please specify.	☐	☐	
e. Drug addiction or alcoholism ?	☐	☐	
f. Psychiatric disorders ?	☐	☐	
g. a job-related injury? If 'Yes', please specify.	☐	☐	
h. Others, which are not specified above.	☐	☐	

NAME OF THE PATIENT: ______________________________

Last Name, First Name, Middle Name

B. Capabilities of the patient

a Given the current condition & extent of disability the patient has suffered, when can they resume their usual occupation?	
b Given the extent of the disability the patient presently has suffered, will it prevent them from performing any kind of work outside their usual occupation?	
c Given the extent of the disability the patient presently has suffered, which of the following daily activities can they not do? (1) continence (2) dressing (3) bathing (4) feeding (5) mobility or transferring in or out of the chair, bed or to walk	

C. If disability was caused by accident

Questions	YES	NO	Please give Details To "YES" Answers
1. Was the patient in good health prior to the injury/disability? If not, please give details.	☐	☐	
2. At the time of the accident/incident, was the patient under the influence of alcohol, illegal drugs?	☐	☐	
3. Place & date of accident			
4. Evidence of any permanent disability the patient sustained as a result of the illness / accident.			

5. Please provide details on any surgical operations performed or contemplated on the patient in the table below.

Date	Name and Address of Hospital	Type of Operation

6. Please provide details of any doctor or specialist who have been consulted in connection with this condition.

Date	Name and Address	Findings	Duration

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

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Date

License No:
Address :