PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT – Hospital Income & Medical/ Surgical Expense Reimbursement Benefit

(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.

A. General Data of the Patient

Name of the Patient	Date of Birth
Are you the patient's regular physician?	How long has the patient been under your care?

B. Hospitalization/Consultation Details

Name & Address of the Hospital /Clinic			
Date of Admission/Consultation	Ward/Room No :	Date of Discharge	
Chief Complaints / Concurrent Conditions			
Laboratory / Diagnostic Procedures conducted			
Date	Laboratory Test	Diagnostic Procedure	Results
Treatment / Medications Given		Diagnosis	
Cause of Hospitalization: ☐ Illness ☐ Accident		Date & Time of Accident Place of Accident	
Extent of Injury : *Please specify below (specify which particular part of the body)*			

NAME OF THE PATIENT : _____

Name, First Name, Middle Name

Is the consultation or treatment for the injury or ailment related or due to:	Please Specify
❑ *Pregnancy, infertility, sub-fertility or childbirth? If for pregnancy, what was the approximate date of commencement?* ❑ *Self-inflicted injury or sexually transmitted disease? Please specify* ❑ *Congenital anomaly, nervous or mental disorder? Please specify.* ❑ *Surgery for cosmetic reasons? Please specify* ❑ *A job-related injury?* ❑ *Infection or out of consequent upon or contributed to by Acquired Immune Deficiency Syndrome (AIDS)* ❑ *Alcoholism or drug addiction* ❑ *Mental or nervous disorders* ❑ *By poison, gas or fumes voluntarily taken* ❑ *Others, which are not specified above*	

Are you the one who duly recommended and approved the hospitalization? YES [ ] NO [ ]	If no, was it the patient's choice? If no, please provide name/s of the other physician/s
Was surgical operation suggested? YES [ ] NO [ ] Was surgical operation performed? YES [ ] NO [ ] *If Yes, please indicate below*	

Date	Type of Operation	Name & Address of Hospital

Was recovery uncomplicated and the period of hospitalization normally expected for this type of case? [ ] **YES** [ ] **NO**	If no, what factors hampered recovery and/or prolonged the period of hospitalization ?
What is your prognosis? GOOD [ ] POOR [ ]	
Do you know of any medical problem/s the patient had in the past ? **YES [ ] NO [ ]** ***if Yes pls provide details*** **below**	

Date	Complaints/Symptoms	Diagnosis	Treatment	From - To

Rehabilitation / Physical Therapy Details :

Date	Hospital/Institution	Type of Therapy	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

Date _____

_____
Signature Over Printed Name of the Attending Physician

License No :

Address :