

ATTENDING PHYSICIAN'S STATEMENT - Crisis Cover (Major Organ Transplant)

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.

*** Instruction : To be accomplished by each attending physician who diagnosed the patient of the illness or condition**

A. General

1. Are you the patient's usual attending physician? If yes, over what period do your records extend?	
2. What are the patient's chief complaint and other symptoms present upon consultation?	
3. When were you first consulted for this condition, and at that time, how long had he/she been experiencing these symptoms?	
4. On which date did the patient become aware of the condition?	
5. Has the patient previously suffered from the condition specified above or any possible related illness?	
6. Do you know of any other medical problem/s the patient had in the past? Please indicate in the table below.	
Date	Hospital/Clinic
Physician	Diagnosis
Treatment	
7. Please give details of the patient's habits in relation to cigarette smoking or drinking.	

B. Medical Details

1. Please provide full and exact details of the diagnosis.	
2. What are the laboratory/ diagnostic procedures conducted?	
3. Has the insured undergone major organ transplantation? If so, please specify.	

NAME OF THE PATIENT :

_____ *Last Name, First Name, Middle Name*

4. What are the treatments / medications given?		
5. In your opinion, is the illness chronic or acute?		
6. What is the prognosis ?		
7. Please give the name and address of all consultants, specialists, hospitals, health centers to which your patient has been referred or attended for this condition.		
Date Attended	Name of the Physician	Address
8. Are there any predisposing or contributory factors in relation to the present illness? If yes, please specify.		

C. Other Information

1. If there is any further information, which in your opinion, will assist us in assessing the claim, Please give details.	
--	--

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

Signature Over Printed Name of the
Attending Physician

Specialization

Date

Address:

License No.: