PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT – CRISIS COVER (Muscular Dystrophy)

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 policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

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?			
3. What were the presenting symptoms?			
4. When did symptoms first present, and how long it had been present?			
5. On which date did the patient become aware of the condition?			

B. Medical Details

1. Please provide dates with full and complete details of the diagnosis.			
2. Date patient was informed of the diagnosis.			
3. Please provide dates & other details of investigations performed and attach copies of all relevant laboratory reports.			
4. Please provide details with dates of all operations performed, treatment and medication.			
5. Is the illness hereditary?	☐	☐	
6. Has the patient previously suffered from the condition (s) specified above or any related illness? If "yes", please give consultation dates and the resulting diagnosis.	☐	☐	
7. Please provide complete name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition.			
8. Is Patient HIV (Human Immuno-Deficiency Virus) positive? If so, please provide details including the date of diagnosis.	☐	☐	

NAME OF THE PATIENT : _____

Last Name, First Name, Middle Name

9. Please provide details of patient's personal and family medical history.	
10. Please give details of the patient's habits in relation to cigarette smoking.	

C. Other information

1. Did the illness permanently prevent the patient from performing activities of daily living without assistance?	
2. If Yes, please mark the type of activity the patient is unable to perform without assistance. [ ] Dressing [ ] Bathing [ ] Eating [ ] Using the Lavatory [ ] Mobility – Does the patient use support devices to move? [ ] YES [ ]NO If Yes , Please specify _____ [ ] Transferring ex: moving in and out of bed or chair	
3. What is the prognosis?	
4. Is there any further information, which, in your opinion, will assist us in assessing the claim?	

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 as valid as the original.

PURPOSE STATEMENT
We will process the information you have provided in this form for the purpose of handling your 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

License No :

Address :