

## ATTENDING PHYSICIAN'S STATEMENT – PRULADY Optional Benefits (Maternity Complications & Congenital Anomaly)

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

**Date of Birth**

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

**A. General**

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 symptoms/condition?	

**B. Medical Details**

**B. 1 Maternity Complications (for Congenital Anomaly Proceed to Questions on B.2)**

1. Please indicate the exact type of disease/illness or complications the patient is diagnosed of.	
2. Please provide dates with full and complete details of the diagnosis.	
3. Date the patient was informed of the diagnosis.	
4. Please provide dates & other details of investigations performed and attach copies of all relevant laboratory reports.	
5. Please provide details with dates of all operations performed, treatment and medication.	
6. How long has the insured been pregnant?	
7. Has the patient previously suffered from the condition (s) specified above or any related illness? If "yes", please give dates of consultation (s) and the resulting diagnosis.	
8. Please provide complete name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition.	
9. Is the patient HIV (Human Immuno-Deficiency Virus) positive? If so, please provide details including the date of diagnosis.	
10. Please provide details of the patient's personal and family medical history.	

NAME OF THE PATIENT : \_\_\_\_\_  
*Last Name, First Name, Middle Name*

### B.2 Congenital Anomaly

Name of the Child (Last Name, First Name, Middle Name)

Date of Birth

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1. Please describe fully the exact illness the above-named is diagnosed of.	
2. Please give exact date of the diagnosis of illness.	
3. How old was the child when the above illness was diagnosed?	

### C. Other information

1. Is there any further information, which, in your opinion, will assist us in assessing the claim?	
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#### 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](mailto:dpo@prulifeuk.com.ph)

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Signature Over Printed Name of the  
Attending Physician

\_\_\_\_\_  
Specialization  
\_\_\_\_\_  
Date

Address : \_\_\_\_\_

License No: \_\_\_\_\_