PRU LIFE U.K.

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

(Instruction : This form shall be accomplished by each and every attending physician on the injury sustained by the insured)

The person whose name appears below is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/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 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 : ______________________________
Last Name, First Name, Middle Name

Is consultation/treatment on injury/ailment is 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 is 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 your Medical Director or any of his/her authorized representative or other person in your 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.

______________________________ Date ______________

Signature Over Printed Name of the Attending Physician

License No :

Address :