The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

Physician's Statement - Disability Claim

INSTRUCTIONS: This form should be submitted to the **Corporate Accounts Division** of The Insular Life Assurance Co., Ltd., 4/F Insular Health Care Building, 167 Dela Rosa corner Legazpi Streets, Legazpi Village, Makati City 1229 or 2/F Insular Life Cebu Business Center, Mindanao Avenue corner Biliran Road, Cebu Business Park, Cebu City.

CLAIMANT

1. Name
2. Address
3. Occupation
4. Age
5. Height
6. Weight

MEDICAL HISTORY

7. Are you his regular physician?
   ☐ Yes ☐ No
8. How long have you known him?
   _____ years _____months _____ days
9. When did you first attend to him for his present illness/injury?
10. Have you previously attended to him? If so,
    When_____ For what? _____
    _____ _____
    _____ _____
11. Has he been treated by any other physician? If so, give their names and addresses.
    _____
    _____
    _____
12. Previous hospital admission/s and treatment/s/
13. What were the earliest indication of illness noted by the inured?
14. What were your objective findings and assessment?
15. Work-up done and results, if any.

DISABILITY

16. Is any surgical operation anticipated or has one been performed? If so,
    What
    When
    Where
    By Whom
17. What is/are your final and complete diagnosis? (etiologic, anatomic, physiologic, functional)
    a)
    b)
    c)
    d)
    e)
18. What are the current abnormal findings?
    a) physical
    b) mental/neurologic:
    1. State of consciousness
    2. Appearance and general behavior
    3. Orientation as to time, place and person
    4. Recent and remote memory recall
    5. Impairment if any of language
    6. Motor function - involuntary Movements, gait disturbance, paresis/plegia if any
    7. Cranial nerve involvement
    8. Others
19. Can the patient...

Yes	No		
☐	☐	a)	wash, bathe, and/or shower (including getting into and out of the bath or shower) such that an adequate level or personal hygiene can be maintained?
☐	☐	b)	put on and take off, secure and unfasten all necessary garments and any braces, artificial limb or other surgical appliances?
☐	☐	c)	move from a bed to an upright chair or wheelchair and vice versa or get on and off a toilet or commode?
☐	☐	d)	move from one room to another on a level surface, in the patients normal place of residence?
☐	☐	e)	manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained?
☐	☐	f)	feed himself once food and drink have been prepared and made available?

PROGNOSIS

20. What is the prognosis?

I, _____ hereby certify that the answers
(Physician's name in full)
given above are full, complete and true, I am a graduate of _____
(Medical College)
_____ in the year _____.

_____
Date

_____
Signature of Insured
(must be signed in the presence of attending physician)

_____
Physician's Signature

_____
Hospital/Clinic Address