The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
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Tel.: (632) 582-1818 • Fax: (632) 771-1717 • TIN 000-464-124 Non-VAT

Physician's Statement – Disability Claim

Please use reverse side for answers requiring additional information and identify your answers with corresponding item numbers.

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 was your last attendance with insured's 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 indications of illness noted by the insured?

14. What were your objective findings and assessments?
_____
_____
_____
_____

15. Work-up done and results, if any.
_____
_____
_____
_____
_____

DISABILITY

16. Is any surgical operation anticipated or has one been performed?
What _____
When _____
Where _____
By Whom _____

17. What is/are your final and complete diagnosis? (etiologic, anatomic, physiologic, functional)
What _____
When _____
Where _____
By Whom _____

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 call _____
5. Impairment if any of language _____
6. Motor function - involuntary _____
Movement, 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 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?

21. When, in your opinion, can he resume his usual occupation or employment?

I,_____hereby certify that the answers given above are complete and true, I ama graduate
(Physician's name in full)
of_____in the year_____.
(Medical College)

_____ _____ _____
Physician's Signature Date Signature of Insured
(must be signed in the presence of attending physician)

_____ Valid until: _____
License No.

Hospital/Clinic Address _____