Allianz PNB
LIFE INSURANCE

Policy No. ☐☐☐ ☐☐☐ ☐☐☐

ATTENDING PHYSICIAN'S STATEMENT FOR LIVING BENEFITS

IMPORTANT NOTICE

This statement must be made by the attending physician of the insured. If more than one physician was employed, the statement of each must be furnished upon on separate forms, which will be sent if required. Indefinite terms as heart failure, exhaustion and the like are to be avoided unless full details are added. Where the spaces set apart for the answers are too small, such details as seem desirable may be given on a separate sheet.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent present or use the same, or to allow it to be presented in support of any claim.

GENERAL INFORMATION

Patient's name _____

Name of hospital _____

Address of hospital _____

Contact nos. of hospital _____ Ward/Room no. _____

Date and time of admission _____ Date and time of discharge _____

Are you related to the patient by blood or consanguinity? _____ If yes, how? _____

Are you the regular physician of the patient? _____ If yes, since when? _____

Did any other physician attend to the patient? _____ If yes, please give details below:

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

DETAILS OF THE ILLNESS

Describe the nature and symptoms of the patient's illness/disease _____

_____

Date the symptoms first occurred _____

What was the diagnosis? _____

Is the disease /illness congenital or hereditary? _____

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Was recovery uncomplicated and was the period of hospitalization normal for a case of this type? ____Yes ____ No

If not, what factors hampered recovery and lengthened the period of hospitalization? _____

_____

What is the patient's progression? _____ Recovered _____Improved _____ Unchanged _____Retrogressed

Is there a possibility of a relapse? ____Yes ____ No . If yes, please explain _____

_____

Details of previous consultations

Date of Consultation	Illness / Diagnosis	Procedure / Operation Done	Prescribed Medication

From what other illness or disease did the insured suffer? Please give, as nearly as you can, the duration of each one

_____

_____

DETAILS OF ACCIDENT

What is the cause of the injury _____

Date and time of the accident _____

Did loss/es or disability occur from bodily injury caused solely by the accident? _____Yes _____No. If no, give details of contributory cause/s.

_____

Was the patient under the influence of alcohol/medication at the time of accident? _____ Yes _____No. If yes, please give details.

_____

PATIENT'S CONDITION

What is the patient's present medical condition?

Is said condition a sole and direct result of the injury/ies sustained from the accident? _____Yes _____No

Is the patient considered to be disabled because of such condition? _____Yes _____No. If yes, for how long will the patient be disabled?

_____

Is such disability _____ Temporary? _____Total & Permanent? Please explain. _____

_____

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What further complications can be expected? _____

_____

PATIENT'S IMPAIRMENTS

Rate/Classify and describe the PHYSICAL impairment/s of the patient as to functional capacity and its limitations.

_____

Rate/Classify and describe the MENTAL/NERVOUS impairment/s of the patient as to functional capacity and its limitations.

_____

PATIENT'S PROGNOSIS AND REHABILITATION

Is the patient now totally able to resume his/her current work? _____Yes _____No. If yes, please explain.

_____

If no, when will the patient be able to return to work? _____

Is there a chance for total recovery? _____Yes _____No. If yes, when do you expect the patient to recover suitably and return to work?

_____

If no, please explain _____

In case the patient is unable to resume his/her current occupation, can he/she be able to engage in other occupations/businesses?

_____Yes _____No. If yes, what would be his/her functional capacity and limitations, if any?

_____

If patient is suitable for other employment, what type of employment would you suggest?

_____

If not, please explain. _____

DETAILS OF THERAPY

Is the patient currently undergoing or has he/she undergone therapy sessions? _____Yes _____No. If yes, please provide details.

Type of Therapy	Period of Sessions	Name of Therapist	Address & Contact No.

Any improvement noted during each therapy? Please elaborate. _____

_____

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FOR FEMALES ONLY

Was the patient pregnant at the time of hospitalization/accident? _____Yes _____No. If yes, for how many months? _____

Was the hospitalization caused directly or indirectly by pregnancy/childbirth? _____Yes _____No. Please explain.

_____

Having been duly sworn, I hereby depose and say that all the statements in the foregoing answers are true and full, to the best of knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at _____, this_____ day of _____, 20_____.

_____
Name and Signature of Witness

_____
Printed Name & Signature of Attending Physician
License No. _____

_____
Address and contact no.

_____
Address and contact no.

On this _____ day of _____, 20_____ personally appeared before me the above named_____, who being by me duly sworn, deposed that the answers to the above questions are full and true, to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

Affiant exhibited to me his/her Residence Certificate No. _____ issued at_____ on _____.

NOTARY PUBLIC

Doc.No._____;
Page No._____;
Book No._____;
Series of _____.

THIS STATEMENT MUST BE MADE BEFORE A NOTARY PUBLIC OR OTHER OFFICER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A MUNICIPAL JUDGE OR BY THE CLERK OF COURT OF RECORD.