GENERALI PILIPINAS
Life Assurance Company

DISABILITY CLAIM PHYSICIAN'S STATEMENT

INSTRUCTIONS: The physician who attended to the insured for his/her disability should accomplish this questionnaire. To facilitate settlement of claim, the physician should give the most accurate and complete information as possible. Please use reverse side for any additional and relevant information not requested in this questionnaire.

1. Claimant's general information
   a. Name _____ c. Apparent age _____
   b. Address _____ d. Occupation _____

2. Are you his/her regular physician? _____ How long have you known him/her? _____

3. Medical history
   a. Date of first consultation for present illness/injury _____
   b. What and when did the claimant note the initial signs and symptoms of the illness?
   _____
   _____
   c. In your professional opinion, when was the illness, which caused the disability acquired?
   _____
   d. Have you previously attended to the claimant for some other reasons?
   If yes, state below the date you so attended to the claimant and the diagnosis:
   _____
   _____
   _____
   _____
   _____
   e. List down the names of other physicians and hospitals, including their respective addresses, whom and that you know have also attended to the patient/claimant:
   _____
   _____
   _____

4. Medical findings:
   a. Significant physical examination findings _____
   _____
   b. Results of laboratory, x-ray, ECG, and other diagnostic examinations
   _____
   _____
   _____
   c. What is your final diagnosis?_____
   d. Is any surgical operation being contemplated or has any surgery or procedure been performed? If so:
   What?_____ Where? _____
   When?_____ By whom? _____

5. Was there any predisposing or contributing cause, remote or recent, for the present disability in the family history, occupation or previous illness of the Insured? If so, describe fully.
   _____
   _____
   _____

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6. Disability:

a. Please classify his disability:

( ) Total permanent ( ) Partial permanent

( ) Total temporary ( ) Partial temporary

b. If partially disabled, what is the degree of incapacity? _____ %

c. If temporarily disabled, when, in your opinion can he resume his usual occupation or employment?

_____

d. What is the prognosis? _____

_____

_____

_____

I, _____. hereby certify that the answers given above are accurate, complete, and true and that claimant presented to me his/her _____ ID no. _____ _____withthe following details (issue and expiration date)_____.

I am a graduate of _____

(Medical School and year)

_____

Signature of Physician over
Name on Print

_____

Signature of Insured/Payor/Guardian over
Name on Print

_____

License/PRC Number

_____

Date

_____

Address

_____

Contact Number/s