Attending Physician's Statement
Critical Condition Rider (CCR)/Critical Illness Benefit (CIB)

Sun Life Financial

Please PRINT clearly.

In this form *you* and *your* refer to the physician while *we*, *us*, *our* and *the Company* refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life Financial group of companies.

The patient is responsible for the completion of this form without expense to Sun Life of Canada (Philippines), Inc.

1 Life Insured / Patient Information (To be completed by the patient)

Name (Last Name, First Name, M.I.)			Date of Birth (day/month/year)
Residence Address (no., street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)
Cell Phone Number	Business Phone Number	E-mail Address	Policy Number(s)
Policyowner (Last Name, First Name, M.I.) Please complete if policyowner is other than the life insured			

Authorization

I hereby authorize the physician named below to release the information requested on this form for the purpose of claim processing. Likewise, I authorize that the information be released to any consulting physician retained by the Company.

Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent
	Date of Signing (day/month/year)

2 Physician's Statement (To be completed by the Attending Physician)

Date you first attended the patient for the disease (day/month/year)	How long do you believe the symptoms had been present when you were first consulted?
Date the patient was informed of the diagnosis (day/month/year)	

1. Provide full and exact details of diagnosis.

2. Please describe the underlying cause of the patient's condition.

3. Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests. Please include dates.)

2 Physician's Statement (To be completed by the Attending Physician) - continued

4. Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? ☐ Yes ☐ No

If No, please provide details.

Since when? (day/month/year)	Activities of Daily Living he/she cannot perform:

5. Has the patient been hospitalized or attended to for any other medical condition? ☐ Yes (please provide details) ☐ No

Name and Addresses of Attending Physician	Date of Consultaion	Diagnosis

6. Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product? .....☐ Yes ☐ No

a) If "Yes", fill out appropriate box with number per day

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

b) If "No", has the patient ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past? ..... ☐ Yes ☐ No

If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product? month/year

7. Are you the patient's regular attending physician? ..... ☐ Yes (please provide details) ☐ No

Period of Consultation	Past Health History

8. Please provide details of physicians to whom the patient had been referred, or who attended to the patient.

9. If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.

3 Signature

Signature of Attending Physician X	Printed Name

PTR No.	License No.	Field of Specialization

Address (no., street, municipality)	City	Province

Country	Zip Code	Phone No.	Cell Phone No.	E-Mail Address

Clinic Hours	Date of Signing (day/month/year)	Place of Signing