ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS / DISMEMBERMENT CLAIM FORM

BPI AIA

NOTE: Fill out ☐ with block letters.
Put ☒ on the tick boxes representing options.
Please use reverse side for answers requiring additional information but not indicated on this questionnaire.
Identify your answers with the corresponding numbers.

PATIENT'S INFORMATION

Name:

Last Name *First Name* *Middle Name*

Date of Birth:

mm / dd / yyyy

Are you related to the patient? ☐ Yes ☐ No
If yes, please state relationship.

Gender: ☐ Male ☐ Female

PHYSICIAN'S STATEMENT *(To be filled up only by a licensed Physician)*

1. Name the Critical illness/Dismemberment the patient is experiencing:
(please refer to insured's policy contract if disease/ailment is covered)

- ☐ Cancer of the_____
- ☐ Cerebrovascular Stroke
- ☐ Coronary Artery Disease/ Bypass Surgery
- ☐ Heart Attack
- ☐ Kidney Failure
- ☐ Liver Cirrhosis
- ☐ Vital Organ Transplant-_____
- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Aplastic Anemia
- ☐ Bacterial Meningitis
- ☐ Benign Brain Tumor
- ☐ Cardiomyopathy
- ☐ Coma
- ☐ Encephalitis
- ☐ Fulminant Viral Hepatitis
- ☐ Heart Valve Replacement
- ☐ Loss of Hearing
- ☐ Loss of Limbs
- ☐ Loss of Sight
- ☐ Loss of Speech
- ☐ Loss of _____
- ☐ Major Burns
- ☐ Motor Neuron Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Poliomyelitis
- ☐ Primary Pulmonary Arterial Hypertension
- ☐ Progressive Bulbar Palsy
- ☐ Progressive Muscular Atrophy
- ☐ Severe Brain Damage
- ☐ Surgery to Aorta
- ☐ Terminal Illness
- ☐ Total and Permanent Disability

a. Date of first consultation: *mm / dd / yyyy*

b. How long has the patient been experiencing said illness from the date of his/her first consultation? (state duration in months) ☐☐ m m

c. Provide full and exact details of diagnosis
(please attach corresponding medical document for diagnosis or use back sheet if necessary)

PHYSICIAN'S STATEMENT *(To be filled up only by a licensed Physician) Continuation*

d. What are its contributory causes?

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

a. Date of test *mm / dd / yyyy*

b. Type of Test

Details:

3. 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 state relevant period.

From *mm / dd / yyyy* Until *mm / dd / yyyy*

a. What activities can the patient not perform?

4. To your knowledge, has the patient been hospitalized or attended to for any other medical condition? ☐ Yes ☐ No

If yes, please give details.

Name of Doctor/Hospital	Complete Address	Dates Attended	Disease or Condition

5. Are you the patient's regular attending phsician? ☐ Yes ☐ No

If yes, please give details on the patient's past health history.

PHYSICIAN'S STATEMENT *(To be filled up only by a licensed Physician) Continuation*

Please answer with a YES or NO

	YES	NO
6. Is the patient's condition a mental or nervous disorder?	☐	☐
7. Is the treatment related to pregnancy, miscarriage, abortion or childbirth?	☐	☐
8. Is the condition sustained from being intoxicated or under the influence of drugs?	☐	☐
9. Is the condition sustained from alcoholism or drug addiction?	☐	☐
10. Is the treatment for routine physical check-up, rest cure, or special nursing care?	☐	☐
11. Is the patient's condition congenital?	☐	☐
12. Is the treatment for cosmetic reasons, a dental treatment or an elective surgery?	☐	☐
13. Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility?	☐	☐
14. Is the patient's condition AIDS-related or due to a sexually transmitted disease?	☐	☐
15. Is the patient's condition an intentionally self inflicted injury or in the intention of suicide or any attempt thereat, while sane or insane?	☐	☐
16. Is the patient's condition a result of homicide, frustrated homicide or any attempt there of, or physical injuries, occassioned by the provocation of the Name Insured?	☐	☐

17. State the hospital name where the patient has/have been confined/ consulted in connection with the mentioned illness/loss:

Name of Hospital	Address (City and Province)	Date of Admission	Date of Discharge
		mm / dd / yyyy	*mm / dd / yyyy*
		mm / dd / yyyy	*mm / dd / yyyy*
		mm / dd / yyyy	*mm / dd / yyyy*

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

Name of Doctor	Complete Address	Dates Attended	Nature of Disease or Condition

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

PHYSICIAN'S DECLARATION

I, _____
Physician's Name in Full: Last Name, First Name, Middle Name

a graduate of _____
Medical College

in the year _____ **with License No.** _____

hereby truthfully certify that the answers given above are full, complete and true.

_____
Physician's Signature

Witnessed by:

_____
Printed name and signature of witness

Date Signed: _____
mm / dd / yyyy

Place Signed: _____

Mobile Number: _____
(09XX-XXXXXXX)

Clinic Address: _____

Clinic Hours: _____

PLEASE DO NOT SIGN ON A BLANK FORM.