Generali Life Assurance Philippines, Inc.
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ATTENDING PHYSICIAN'S STATEMENT – DISABILITY CLAIM

Note: Kindly submit this form to Generali Life Assurance Philippines, Inc., (GLAPI) duly completed by a qualified and registered physician at the expense of the claimant.

PATIENT'S DETAILS

Last Name	First Name		Middle Name
Address			
Date of Birth (MM/DD/YYYY)	Place of Birth	Age	Status
How long have you known the patient?			
When did the patient first consult you?			
Please state the date symptoms were noticed and describe in detail.			
What is the final diagnosis?			
If Surgical Procedure was performed, please describe in detail and provide copy of the Operation Room Record.			
Is the patient able to perform any and every duty of his own occupation? ☐ Yes ☐ No			
If yes, when is he/she expected to return to his/her usual occupation?			
If no, when did he/she cease all work.			
In your opinion, is the patient totally and permanently disabled and unable to engage in any occupation or perform any work for income or profit currently or at anytime thereafter. ☐ Yes ☐ No			
Please classify his disability. ☐ Total Permanent ☐ Partial Permanent ☐ Total Temporary ☐ Partial Temporary			
Please provide full detail of the capabilities and limitations of the patient. Capabilities (What the patient can do)			
Limitations (What the patients cannot do)			

PLEASE GIVE DETAILS OF THE PATIENT'S PREVIOUS CONDITIONS FOR WHICH YOU ATTENDED PRIOR TO LAST ILLNESS/INJURY:

Date of Attendance	Diagnosis	Treatment/Procedure

ARE YOU AWARE OF ANY OTHER CONSULTATION OR CONFINEMENT OF THE PATIENT FOR ANY ILLNESS OR INJURY, IF SO PLEASE PROVIDE INFORMATION BELOW:

Date of Attendance	Name of Physician/Address	Medical Institution/Address	Diagnosis/Treatment/Procedure

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I HEREBY CERTIFY that the above statements are true and complete to the best of my knowledge and belief.

Dated at ______________________ this ______________________ day of ______________________ 20 ______________.

____
SIGNATURE OVER PRINTED NAME OF PHYSICIAN

____
QUALIFICATION

____
ADDRESS

____
CONTACT DETAILS

SUBSCRIBED AND SWORN to me this ______________________ day of ______________________ ,20 ________ by the aboce claimant who exhibited to me his/her Residence Certificate No. __________________ issued at ______________________ on ______________________ .

Doc No. __________________ Book No. __________________
Page No. __________________ Series of __________________
My Commission expires on __________________

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NOTARY PUBLIC