Waiver of Premium / Disability Benefit Claim Form

To be completed by Attending Physician

Policy Number | | | | | | | | |

1. Information of the insured

Name of Insured (Title, First Name, Middle Name, Last Name)

2. Attending physician's statement

To enable us to evaluate the claim for Critical Illness Benefit, this section must be completed by the Attending Physician providing complete and detailed answers to the following questions:

Association with the Patient

1. Are you the regular physician of the patient? ☐ Yes ☐ No
2. Are you related to the patient? If Yes, please state relationship: ☐ Yes ☐ No
3. How long have you known the patient? _____

General Information

1. Choose if condition of the patient was due to: ☐ Disability ☐ Critical Illness ☐ Death

2. Provide details for the following:

a. Date you were first consulted by the patient for this condition.	
b. What are the signs/symptomps experienced by the patient?	
c. Date signs/symptoms were first experienced	
d. How long do you believe the signs/symptoms had been present when you were first consulted?	
e. Describe the underlying cause of patient's condition.	

3. Details of diagnosis:

a. Provide full and exact details of diagnosis including the history of illness or how the injury was sustained.	
b. Date of Diagnosis.	
c. Date the patient was informed of the diagnosis.	

4. In case of death of the patient, provide details of the following:

a. Date of death (mm/dd/yyyy)	b. Place of death
c. Cause of death	

5. Is the patient's condition caused by or a result of alcohol or drug abuse? ☐ Yes ☐ No
   If Yes, why do you believe so? Please provide details.

6. Objective findings supporting the diagnosis and prognosis.
   (include any results of histopath, currentX-rays, ECG, MRI, or any other special tests, please indicate inclusive dates)

7. Can the patient:

	Yes	No	If "No" please state duration (mm/dd/yyyy)
a. move from a bed to an upright chair or wheelchair and vice versa?	☐	☐	
b. move indoors from room to room on level surface?	☐	☐	
c. use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene?	☐	☐	
d. put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or surgical appliances?	☐	☐	
e. wash in the bath or shower (including getting into and out of the bath shower) or to wash satisfactory by any other means?	☐	☐	
f. feed himself once food has been prepared and made available?	☐	☐	

8. List down all current physical and mental/neurologic disabilities of the patient as a result of the illness or injury

8.1. Physical Findings:	
8.2. Mental/Neurologic:	
a. State of consciousness	
b. Appearance and general behavior	
c. Orientation as to time, place and person	
d. Recent and remote memory recall	
e. Language impaiment, spoken or written	
f. Cranial nerve involvment	
g. Motor function (involuntary movements, gait disturbance, paresis, plegia if any)	

9. Classify the neurologic condition of the patient and state the reason and evidence why you believe so.

☐ Permanent neurologic damage

☐ Temporary neurologic damage

10. Classify the disabilty of the patient and state the reason and evidence why you believe so

☐ Total and permanent disability

☐ Partial disability

11. Is the patient's condition caused by or a result of alcohol or drug abuse? ☐ Yes ☐ No
If Yes, why do you believe so? Please provide details.

12. Provide details of hospital and physicians to whom the patient had been referred to for any other medical condition.

Name of Hospital and Physician	Date of Consultation / Period of Confinement	Medical condition

13. Was there any surgical operation performed on the patient? If Yes, please provide details: ☐ Yes ☐ No

Operation:	
Date of Operation	
Hospital	
Physician/s:	

14. If you are the patient's regular physician, please provide details of your attendance with the patient

Date of consultation	For what reason have you attended the patient

15. State what treatments, examinations or procedures has the patient undergone. (Give full details including chemotherapy, radiotherapy, dialysis, surgery and medications, if any.)

Treatment, examination, procedure, surgery, medications	Inclusive Dates	Number of Session

16. Provide details of the following:

a. Is the patient wholly disabled and prevented from engaging in any business or occupation whatsoever? ☐ Yes ☐ No

b. When did the patient cease to work because of his disability/illness? _____

c. When, in your opinion, may patient be expected to resume to work? _____

17. What is the prognosis on the condition of the patient?

18. Is there any further information which in your opinion will assist us in assessing this claim? Please provide information below.

3. Attending physician's affirmation

This is to certify that the above statements are true and complete to the best of my knowledge and belief. I allow FWD to collect and store my personal data specified below to process this Claim Form and contact me for any clarification regarding the statements I provided in this Form.

_____
Attending Physician's Signature over Printed Name

_____
Date Signed

_____
Complete Clinic/Hospital Address

_____
Telephone number / Mobile Number

Lic No: _____
PTR No: _____

_____
Field of Specilalization

_____
Email Address

Please do not sign on blank form