Critical Illness Claim Form

To be completed by Attending Physician

Policy Number | | | | | | | | | |

Please fill in block letters and tick the appropriate boxes and circles.

1. Patient Information

Name of Patient

Title	First Name	Middle Name	Last Name	Ext Name
Date of Birth		Occupation		

Authorization

I hereby authorize any physician, surgeon or other person, organization or entity that has any record or knowledge of my health to disclose to FWD or its authorized representative, the Medical Information Bureau or any government agency requiring such. This authorization is in connection with the application for Claims.

Place of signing _____ Date: m m / d d / y y y y

Policy Owner's Signature over Printed Name | Insured Signature over Printed Name | Agent/Witness

Notes: (1) This section must be signed by the person Insured, the parent if applicable, and the Policyowner, if he/she is not the person Insured. (2) If this form will be signed outside the Philippines, please have the form authenticated by the nearest Philippine Embassy or Consulate in your locality. (3) The witness should be a disinterested adult person.

2. 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? _____

3. Physician's Statement (Please provide COMPLETE and detailed answers to the following questions)

1. State the Critical Illness of the patient:

2. Date of commencement of illness (mm/dd/yyyy) _____

3. Provide details of the following:

a. Date you first attended the patient for the medical condition.	(mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___
b. Date the patient was informed of the diagnosis.	(mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___
c. How long do you believe the signs/symptoms had been present when you were first consulted? (please state duration)	

4. Provide full and exact details of diagnosis including the history of illness or how the injury was sustained.

5. Describe the underlying cause of patient's condition.

6. 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.)

7. Can the patient: (please check answer)

	Yes	No	If "No" pls 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 satisfactorily by any other means?			
f. feed himself once food has been prepared and made available?			

8. If condition was due to accident, was the patient under the influence of alchohol, any intoxicating drinks, drugs or narcotics at time of accident? If yes, why do you believe so? Please give particulars. Yes No

POLICY NUMBER: _____

9. List down all current physical and mental/neurologc disabilities of the patient as a result the illness

9.1. Physical:	
9.2. 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	

10. The neurologic condition of the patient can be classifiied as:
Permanent neurologic damage
Temporary neurologic damage

11. Please answer by a Yes or No

	Yes	No
a. Does the patient refuse to consent to treatment or defy the advice of a Medical Practitioner?		
b. Is the patient's condition a result of attempted suicide or intentionally self-inflicted injury while sane or insane?		
c. Is the patient's condition congenital?		
d. Is the patient's condition a result of any nuclear, biological, radioactive and chemical contamination?		
e. Is the patient's condition an HIV or AIDS related?		
f. Does the patient drink alcohol?		
g. Does the insured smoke cigarettes/cigars or consume any other tobacco products or prohibited drugs?		
For any "YES" answer, please provide details below:		

12. Has the patient been hospitalized or attended to for any other medical condition? If Yes, please provide details. Yes No

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 patienr's regular physician, please provide details of your attendance with the patient

Period of Consulation	Past Health History

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

Name and Address of Physician	Date Attended	Disease or Impairment

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

17. Is there any further information which in your opinion will assist us in assessing this claim, please furnish information below.

4. Affirmation Section

Place of signing _____ Date: m m / d d / y y y y

_____ Attending Physician's Signature over Printed Name

_____ Complete Address

_____ Telephone number / Mobile Number

Lic No: _____
PTR No: _____

_____ Field of Specilalization

_____ Email Address

5. Data Protection

FWD has appointed a Data Protection Officer to handle any inquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Corporation Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 19/F, W Fifth Avenue Bldg., 5th Avenue cor. 32nd Street, Bonifacio Global City, Taguig City 1634, Philippines.

PLEASE DO NOT SIGN ON A BLANK FORM.