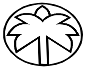

COCOLIFE

COCOLIFE Bldg., 6807 Ayala Avenue, Makati City 1226
MCC PO Box 1681 * Tel. No. (632) 812-9015 Fax No. (632) 812-9038
Website: www.cocolife.com

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

INSTRUCTION: This form shall be accomplished by each and every physician on the injury / sickness sustained. Please answer fully all questions.

SECTION 1: PATIENT'S IDENTIFICATION

Name: LAST NAME FIRST NAME MIDDLE NAME
____

DATE OF BIRTH: ______________________

OCCUPATION: ______________________
ADDRESS: NO. STREET CITY OR TOWN PROVINCE ZIP CODE
____

____

Telephone number: Home: _________________ Cellphone: ________________

E-mail address: __________________________________

SECTION 2: PATIENT'S AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize any physician, hospital or other institutions having records about the disability/illness that is the basis for my request to make information from these records available to COCOLIFE and its authorized representative.

I understand that under Article 175 of the Revised Penal Code using false medical certificate is punishable by law.

Signature of Patient or Representative Date

_______________________________________ _________________________________

Printed Name of Patient or Representative Representative's Relationship to the Patient (if applicable)

_______________________________________ _________________________________

Address of Representative (if applicable)

____

SECTION 3: AFFIDAVIT OF PHYSICIAN

Instructions to Physician: The patient identified above is applying for ____________________________. You should complete and sign the certification below only if you are a doctor of medicine legally authorized to practice in the Philippines and not a relative up to the third degree of the patient above. Provide all requested information and attach additional pages if necessary. Type, print or write in black or blue ink.

1. Are you the patient's usual medical practitioner? ☐ Yes / ☐ No

   How long have you known the patient? _________________

2. Diagnosis of the patient's present medical condition. Do not use abbreviations or codes.

   Primary diagnosis: ____ Date: _________________

   Secondary diagnosis: ____ Date: _________________

   Other diagnosis: ____ Date: _________________

3. Physical Examination

Please describe fully the nature of the patient's disability	______________________________ ______________________________
Vision (Visual acuity):	<table><tr><td></td><td>Right</td><td>Left</td></tr><tr><td>Normal</td><td></td><td></td></tr><tr><td>Impaired</td><td></td><td></td></tr><tr><td>Scores based on Metric Acuity</td><td></td><td></td></tr></table>Remarks:______________________________ ______________________________
Hearing:	<table><tr><td></td><td>Right</td><td>Left</td></tr><tr><td>Normal</td><td></td><td></td></tr><tr><td>Impaired</td><td></td><td></td></tr><tr><td>Scores based on speech reception threshold (audiometry)</td><td></td><td></td></tr></table>Remarks:______________________________ ______________________________
Function of Speech:	☐ Clear and understandable ☐ Slurred ☐ Unable to speak Remarks:______________________________ ______________________________
Cognitive Function: ☐ Normal ☐ Poor comprehension ☐ Difficulty with logic and reasoning ☐ Memory loss Remarks:______________________________ ______________________________ ______________________________ ______________________________	**Mental Status:** ☐ within normal limit **Development** (☐ good, ☐ fair, ☐ poor) **Behavior** (Alert, lethargic, confusion, speech) **Orientation** (Time, person, place & situation) **Memory/Concentration** ☐ Name president/recent newsworthy events ☐ 3 word or place recall at 0 and 5 minutes ☐ (100) – (7) up to five times (93, 86, 79…) ☐ Spell word backwards ☐ Draw a clock (make the time 12:30) ☐ Draw overlapping pentagons Remarks:______________________________ ______________________________
General Finding: (i) Are there any abnormal movements or abnormal gait? (Please provide full details) (ii) Is there any muscle wasting? (iii) Is there any other significant examination findings? (Please provide full details)	(i) ______________________________ ______________________________ ______________________________ (ii) ______________________________ ______________________________ (iii)______________________________ ______________________________

Examination of the Limbs:

Please indicate the muscle power of the various joints in the table below with maximum grade of 5

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks:

Assessment of Activities of Daily Living:

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer (Getting in & out of chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			
Using cellular phones, computer, calculator, writing, reading			
Bathing (brushing teeth, application of soap and shampoo, rinsing with water without assistance of another person)			

Remarks:

4. The patient's disability is best described as

   ☐ progressively worsening

   ☐ has reached maximum medical improvement. (If checked here proceed to 6)

   ☐ medical improvement can still be attained.

5. If improvement can still be attained it will be through:

   ☐ physical therapy ☐ others, please specify: ___________________________

   Please specify medical/surgical treatment plan:

   ____
   ____
   ____

   Improvement is expected to be on (month, day, year) ______________.

6. Last treatment/therapy done was (kind of therapy) ___________________ on __________________.

7. Is full recovery expected if a medical/surgical treatment can be given? ☐ Yes / ☐ No

8. (i) Is the patient able to perform all the normal duties of his/her occupation? ☐ Yes / ☐ No
   If yes, when is he/she expected to return to his/her usual occupation? ________________

(ii) If he/she is unable to return to his/her usual occupation, is he /she be able to engage in any other occupation? ☐ Yes / ☐ No

(a) What types of occupation can he/she be engaged in? ___________________________

(b) When is he/she expected to engage in this occupation? _________________________

9. How would you classify the patient's disability?

☐ Total Permanent Disability ☐ Total Temporary Disability
☐ Partial Permanent Disability ☐ Partial Temporary Disability

10. PHYSICAL & / OR MENTAL IMPAIRMENT.

Please check one that best describes the patient's condition:	
	No limitation; may return to work.
	Slight limitation; capable of light work.
	Moderate limitation; capable of sedentary work.
	Cannot perform present work but capable of performing another line of work.
	Temporary limitation of functional capacity; temporary incapable of any kind of work.
	Severe limitation of functional capacity; permanently incapable of any kind of work thus no medical or surgical treatment can relieve, improve symptoms or cure his/her condition.
Remarks:	

I certify that I have personally examined the physical condition of the patient individual and that I have answered the questions truthfully and to the best of my knowledge and belief. I understand that under Article 174 of the Revised Penal Code, issuing false medical certificates of any physician or surgeons is punishable by law.

SIGNATURE OF PHYSICIAN Date

______________________________ ________________________

PHYSICIAN NAME AS IT APPEARS IN THE PRC LICENSE:

____

LAST NAME FIRST NAME MIDDLE NAME

REGISTRATION NO. (PRC ID NUMBER): _______________________

VALID UNTIL: ___________________

BUSINESS ADDRESS: (NO. STREET/ CITY OR TOWN/ PROVINCE/ ZIP CODE)

____

____

TELEPHONE/CELLPHONE: ____________________________

SPECIALTY/SUBSPECIALTY: ___________________________

Privacy Information Cocolife recognizes the importance of protecting you and your patients' personal information, and is committed to complying with its privacy law obligations.

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."