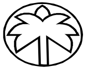

COCOLIFE

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

TERMINAL ILLNESS - PHYSICIAN'S STATEMENT

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

SECTION 1: INSURED'S IDENTIFICATION

Name: SURNAME 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: INSURED'S REQUEST

I request COCOLIFE ***to grant, Terminal Illness Living Benefit (TILB).***

I authorize any physician, hospital or other institutions having records about my 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 fraudulent medical certificate is punishable by law.

Signature of Insured or Representative ______________________________ Date ______________________________

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

Address of Representative (if applicable)

____

SECTION 3: AFFIDAVIT OF PHYSICIAN

Instructions to Physician: The insured identified above is applying for Terminal Illness Living Benefit. 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 insured 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 insured's present medical condition. Do not use abbreviations or codes.

   Primary diagnosis: ____

   Secondary diagnosis: ____

   Other diagnosis: ____

CLAIMS-043-0517-2

Five (5) pertinent Medical Records provided by the patient which confirmed diagnosis (please make sure that these are attached):

___ Discharge Summary
___ Medical Abstract
___ Imaging studies such as __ X-rays, __ Ultrasound, __ MRI, __ PET scans
Anatomic part: _____
___ Laboratory Results: __ CBC
Others (please specify) ____
___ Histopathologic report / biopsy reading

3. When did the insured's current medical condition start? Month _______________ Day ___ Year ________

4. When was the patient first diagnosed as having a life expectancy of less than _____ (months/years) _________________________?

5. Is there any relevant condition in the patient's family history which would have increased the risk of the disease? [ ] Yes [ ] No if yes, please give details.

6. Does the patient have or ever had any other significant health condition? If yes, please provide details of the condition, including diagnosis, date of diagnosis and treatment received.

7. What is the nature of treatment?

   Surgical [ ] Chemotherapy [ ] Radiotherapy [ ] Palliative [ ] Others [ ]

   Please provide details of procedure (s).

8. Nature of medical condition. The medical condition was a result of
   ___ an accident
   ___ his occupation
   ___ other predisposing medical illness
   ___ hereditary, genetic, familial predisposition

9. If you are not the first doctor who diagnosed the patient with the condition, please state the doctor/s who has seen the patient prior to you.

Name of Doctor	Address	Phone number	Specialty	Date(s) of Consultation or Inclusive period of management

10. Based on your medical opinion, the patient has an injury or illness that is likely to lead to death within

___ Less than 6 months from the date of this report
___ 6 to 12 months from the date of this report
___ 13 to 24 months from the date of this report
___ More than 24 months from the date of this report

11. Provide details of your patient's significant medical history that are not included in the attachments (number 5 above) submitted to you. Include past, present and future treatment such as chemotherapy, radiotherapy, dialysis, palliative care, among others.

____

I certify that I have personally examined the physical condition of the insured 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 NUMBER: ___________________________

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."