MANILA BANKERS LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

DISABILITY CLAIM FORM NO. 2

CERTIFICATE OF ATTENDING PHYSICIAN

POLICYHOLDER _____ CLAIM NO. _____

MASTER POLICY NO. _____ POLICY/CERTIFICATE NO. _____

1. Name of Claimant _____ 2. Age _____
3. Residence Address _____
4. Occupation _____ 5. Height _____ 6. Weight _____
7. Are you his regular physician? _____ 8. How long have you known him? _____
9. When did you first attend to him for his present illness/injury? _____
10. Had you previously attended to him? YES ( ) NO ( ) If yes:

WHEN	FOR WHAT
_____	_____
_____	_____

11. Has he been treated by any other physician? YES ( ) NO ( ) If yes, please give their name(s) and address(es).

_____

_____

12. Has he received treatment in any hospital, sanitarium or other institution? YES ( ) NO ( ) If yes, please state name and address.

_____

13. What and when were the earliest indications of illness noted by the insured? Give your basis. _____

_____

14. In your opinion, when did the illness, which directly or indirectly caused the disability, commence? _____
15. Was he in good health up to the time of his present illness? YES( ) NO( ) If not, give details. _____

_____

16. How would you classify his disability? ( ) Partial Temporary ( ) Partial Permanent ( ) Total Temporary ( ) Total Permanent

If partial, what in your opinion is the degree (percentage) of incapacity? _____

_____%

17. If totally disabled, state when the total disability commenced and for how long. From _____ To _____

_____

18. Please state your diagnosis of his case. _____

_____

Interpretations, if any, of: Laboratory reports _____

_____

X-ray _____

_____

Electrocardiogram(s) _____

_____