MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

ACCIDENT CLAIM FORM NO.2

CERTIFICATE OF ATTENDING PHYSICIAN

POLICYHOLDER/CREDITOR _____ CLAIM _____

MASTER POLICY NO. _____ POLICY/CERTIFICATE NO _____

INSTRUCTIONS:

This statement should be sworn to before a notary public or other officer duly authorized to administer oaths and his official seal attached, or if he has no seal, his authority and the genuineness of his signature must be attested by a Justice of the Peace or by the Clerk of Record.

This form should be accomplished at the Insured's expense.

1. a. Name of Claimant _____
   b. Residence Address _____
   c. Present Occupation _____
2. a. Describe fully the particulars of the accident and how it occured:
   Date _____ Time _____ AM/PM Place _____
   Cause of the accident _____
   b. Did the accident occur during the performance of the occupation?
   YES ( ) NO ( ) If yes, describe fully _____
   _____
   _____
   c. What was the nature of the claimant's occupation immediately prior to the accident?
   _____
   _____
   d. How long after the accident did you see the victim-claimant? _____ Where did you see him/her? _____
3. a. State fully the exact nature and extent of the injuries sustained. If to arm, leg or eye, state whether RIGHT or LEFT. _____
   _____
   _____
   _____
   b. Are the injuries and their present conditions sufficiently accounted for by the description of the accident given on the Certificate of Claimant? YES ( ) NO ( )
   If not, what is your opinion? _____
   _____
4. a . TOTAL DISABILITY — State whether the patient is confined to hospital/house and prevented from pursuing his usual business or occupation as a direct result of his injuries. Give details. _____
   _____
   _____
   b. PARTIAL DISABILITY — State whether he is up and about and able to perform some of the duties of his business or occupation. Give details. _____
   c. State how long in your opinion the claimant will be so disabled.
   TOTAL DISABILITY: From _____ to _____
   PARTIAL DISABILITY: From _____ to _____
5. a. How would you classify his disability?
   ( ) Total Permanent ( ) Partial Permanent
   ( ) Total Temporary ( ) Partial Temporary
   b. If partial, what in your opinion is the degree of incapacity?
   _____
   _____
6. a. State the nature of treatment given to, or surgical operation performed on the victim since the accident:
   Nature of treatment _____ By whom _____
   When _____ Where _____
   b. Describe briefly the patient's present condition and what after effects there are or could be expected, if any, as the sole and direct result of the accidental injury. _____
   _____
7. Is the patient now or was he at the time of the accident suffering from or affected by any physical infirmity, disease or illness (cardiac, gout rheumatism or fits of any kind, etc.) which have contributed, directly or indirectly, to the occurrence of the accident or which may likely in any way retard his recovery from the accident? YES( ) NO( ) If yes give details _____
   _____

8. In your opinion, was he under the influence of liquor or any other intoxicating drink or drug, at the time of accident? YES( ) NO( )

9. a. Are you the claimant's regular physician? YES( ) NO( ) How long have you known him?_____

b. Have you attended him for any illness or accident? YES( ) NO( ) If yes, what and when? _____

c. Have you any reason to believe he has ever had a previous accident or that he has ever claimed upon any Accident Insurance Company? YES( ) NO( ) If yes, state the reason(s) _____

_____

_____

d. Has he received treatment in any hospital, clinic or other institution? YES( ) NO( ) If yes, give:

Name(s) of Institution	Attending Physician(s)
_____	_____
_____	_____

I, _____, hereby certify that the answers given above are full, complete and true. I am a
(Printed name of Physician)

graduate of _____ in _____.
(Medical College)

AUTHORIZATION

This authorizes the MANILA BANKERS LIFE or its authorized representative to secure clinical/hospital records relative to the subject's illness, sickness or injury. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Dated and signed at _____ **on** _____

_____
Physician's Signature

PRC NO. _____

Date Issued _____

Place Issued _____

_____
Full address of Physician