MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

TERMINAL ILLNESS CLAIM FORM NO. 2

CERTIFICATE OF ATTENDING PHYSICIAN

1. Name of Claimant/Patient _____ 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. What and when were the earliest indications of his present illness noted by the insured? Give your basis. _____

_____

_____

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

_____

_____

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

_____

_____

Describe the treatment received. _____

_____

14. Was he in good health up to the time of his present illness? YES ( ) NO ( ) If not, give details. _____

_____

15. Please state your diagnosis of his case. _____

_____

Date Diagnosed _____ (month/day/year). Interpretations, If any, of Diagnostic reports.

_____

_____

_____

16. Was there any predisposing or contributing cause, remote or recent, for the present illness in the habits, family history, occupation or previous illness of the insured? YES ( ) NO ( ). If yes, describe fully _____

_____

17. Is any surgical operation contemplated or has one been performed? YES ( ) NO ( ). If yes, please state:

Nature of operation _____ When _____

Where _____ By whom _____

18. Is the patient totally disabled? YES ( ) NO ( ). If YES, date total disability began _____
(month/day/year)

19. Please check the one which best indicates your estimate of the patient's life expectancy

☐ 12 Months or Less ☐ 13 to 18 Months ☐ 19 to 24 Months ☐ More than 24 Months

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

_____ in _____.
(Medical College)

AUTHORIZATION

This authorizes the MANILA BANKERS LIFE INSURANCE CORPORATION 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.

Date and signed at _____ on _____

_____
Physician's Signature

PRC No. _____

Date Issued_____

Place Issued_____

_____
Full address of Physician