MANILA BANKERS LIFE INSURANCE CORPORATION

The best way to show your Love

CRITICAL ILLNESS CLAIM FORM NO. 2

CERTIFICATE OF ATTENDING PHYSICIAN

1. Name of Claimant-Patient_____ Insurance Certificate No._____

2. Age _____ 3. Residence Address _____

4. Occupation _____ 5. Height _____ 6. Weight _____

7. Claim Condition Suffered (Please check)

[ ] Cancer	[ ] Apallic Syndrome	[ ] Fulminant Viral Hepatitis
[ ] Myocardial Infarction	[ ] Aplastic Anemia	[ ] Motor Neurone Disease
[ ] Stroke	[ ] Bacterial Meningitis	[ ] Muscular Dystrophy
[ ] Coronary Artery Surgery	[ ] Benign Brain Tumor	[ ] Parkinson's Disease
[ ] Renal Failure	[ ] Chronic Liver Disease	[ ] Poliomyelitis
[ ] Major Organ Transplant	[ ] Encephalitis	[ ] Pulmonary Arterial Hypertension
[ ] Multiple Sclerosis	[ ] End Stage Lung Disease	[ ] Alzheimer's Disease

8. Are you his regular physician _____ 9. How long have you known him? _____

10. When did you first attend to him for his present illness/injury? |__|__|__|__|__|__|

11. If consultation was for illness, please provide the following information:

(a) Symptoms presented _____

(b) Duration of these symptoms _____

(c) Diagnosis _____

(d) Was the diagnosis made known to the patient? [ ] YES [ ] NO

If YES, when? If NO, why?

_____

(e) If consultation was for injury(ies) please described injuries:

_____

_____

12. **Patient's Condition**

(a) Please describe the nature and severity of the patient's illness

_____

(b) To what extent does his illness prevent him from performing all the normal duties of his usual occupation?

_____

13. **Please describe treatment, including any operations performed.**

_____

14. **If the patient was referred from a clinic or hospital, please state:**

(a) Name of physician _____

(b) Name of clinic/hospital _____

(c) Date referred |__|__|__|__|__|__|

15. Has patient been admitted to hospital before for the same illness/injury (ies)? [ ] YES [ ] NO

If YES, please state:

_____

(a) Date admitted |__|__|__|__|__|__| (b) Date discharged |__|__|__|__|__|__|

(c) Name of hospital _____