FORTUNE LIFE INSURANCE CO., INC.
Fortune Life Building, 162 Legazpi Street
Legazpi Village, 1229 Makati City
Tel. Nos.: (02) 892-9841 to 49 (connecting all dept's)
Fax No.: (02) 812-2703
e-mail address: fortlife@fortunelife.com
URL http://www.fortunelife.com

PHYSICIAN'S STATEMENT / DISABILITY CLAIM

CLAIMANT

1. Name: _____
2. Address: _____
3. Occupation: _____ 4. Apparent Age: _____
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 _____

MEDICAL HISTORY

10. Have you previously attended him? _____. If so:
    When? For what?
    _____ _____
    _____ _____
    _____ _____

11. Has he been treated by any other physician? _____. If so: Give their names and address:
    _____ _____
    _____ _____
    _____ _____

12. Has he received treatment in any hospital, sanitarium or other institution?_____. If so, state and where:
    _____
    _____

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

14. When, in your opinion, 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? _____. If not, give details:
    _____
    _____

16. How would you classify his disability?
    _____ Total Permanent _____ Total Temporary
    _____ Partial - Permanent _____ Partial Temporary

    If partial, what in your opinion is the degree of incapacity? _____%

17. If totally disable, since when? _____

18. Is he now totally disabled?_____
    _____

19. What is your diagnosis? _____
    _____
    _____
    _____
    Interpretation: If any, of Laboratory Report: _____
    _____
    _____

ANTI FRAUD WARNING / PAALALA:

"***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."***

XRay: _____
_____
_____

Electrocardiogram (ECG): _____
_____

20. Was there any predisposing or contributing cause, remote or recent for the present disability in the family history, occupation or previous illness of the insured? _____.
If so, describe fully:
_____
_____

21. Is any surgical operation contemplated or has one been performed? _____ If so:
What?: _____
When?: _____
Where?: _____
By whom?: _____

22. What is your prognosis? _____
_____
_____

23. When in your opinion, can be resume his usual occupation or employment? _____
_____
_____

NOTE: Please use additional paper for answers requiring additional information not called for in the questionnaire. Identify your answers with the corresponding item numbers.

I _____, hereby certify that the answers given above are full, complete and true. I am a graduate of _____ in the year _____.

_____
Physician Signature

_____
Date

_____
Print Name

License No.: _____
Address: _____

_____
Signature of Insured
(Must be signed in the presence of the Attending Physician)

SUBSCRIBED AND SWORN to before me this _____ day of _____ by the above claimant who exhibited to me his/her Res. Cert. No. _____ issued at _____ on _____.

_____
Notary Public

Doc. No.: _____
Page No.: _____
Book. No.: _____
Series of: _____

Until December 31, 20 _____
PTR No. _____
Issued On: _____
Issued at: _____

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