The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

I-Heal

INSTRUCTIONS TO CLAIMANT:

1. This form (I-Heal Claim - Sickness Form III) must be completed by the ATTENDING PHYSICIAN of the Insured. (If not applicable, please write N/A in the space provided for.)
2. The following must be submitted, along with this form:
   2.1. Insured's Statement of Claim (I-Heal Claim - Sickness Form I), as applicable;
   2.2. Hospital's Certification (I-Heal Claim Form II);
   2.3. Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed; and,
   2.4. All required documents indicated in the above-listed forms.
3. Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

PHYSICIAN'S STATEMENT
(I-HEAL CLAIM - SICKNESS FORM III)

1. Name of Patient: _____
   (Given Name) (Surname) (Suffix)

2. Patient's Occupation:

3. Describe fully the nature of the illness.

4. Date first symptoms were discovered:
   Date of first examination/treatment:

5.1. What treatment/s, special examinations and/or procedures (ECG, x-ray or other diagnostic tests) has the patient undergone? Please give full details stating the nature of treatment, and/or examination, findings, diagnosis and prescribed regimen/medicines.

5.2. If confined, state period/s of confinement and name and address of hospital:

From	To	Name of Hospital	Address of Hospital

5.3. Was any surgical operation performed? If so, please provide the following details: Nature of operation:

Date of operation:

Place:

Physician/Doctor who performed the operation:

6. What is/are your final and complete diagnosis?

7. What is the prognosis?

8. Have you previously attended to the patient? If so,

When _____ For What _____

9. How long has the patient been under your treatment?

From To

_____ _____

Month Day Year Month Day Year

10. Do you have any information if the patient is suffering from any disease, illness or abnormality aside from his/her illness you treated? If so, please provide details:

Nature of abnormality or illness	From	To

11. Did the patient himself provide the information in no. 10?
If not, please indicate name of informant and his/her relationship to the patient.

_____

_____

_____

12. Did the abnormality, disease or illness retard in any way the patient's recovery from his/her illness? If so, how and to what extent?

_____

_____

_____

I,_____hereby certify that the answers given above are full, complete andtrue.
(Physician's Full Name)

_____
Physician's Printed Name & Signature
License No.:_____
Valid until:_____

_____
Date Signed

_____
Name and Signature of Witness

_____
Date Signed

SUBSCRIBED AND SWORN to before me this_day of_____20_, by the above claimant who exhibited to me his/her government issued ID/Passport No._____, issued at_____on___.

Doc. No. _____
Page No. _____
Book No._____
Series of_____.

NOTARY PUBLIC
My Commission expires on _____