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

Physician's Statement
(I-Shield Claim Form III)

INSTRUCTIONS:
(1) This form is to be accomplished completely (if not applicable, please write N/A in the space provided for) by the Attending Physician and must be submitted together with the following: INSURED'S STATEMENT (I-Shield Claim Form I-A) **OR** CLAIMANT'S STATEMENT (I-Shield Claim Form 1-B) as may be applicable.
(2) Submit the accomplished claim forms to POLICY BENEFITS AND SERVICING SUPPORT DEPARTMENT, THE INSULAR LIFE Assurance, Co., Ltd., Insular Life Corporate Center, Insular Life Drive, Filinvest Corporate City, Alabang Muntinlupa City, Tel. Nos. 582-18-18 Loc. 4407 & 4408 or to any Insular Life District Offices.

1. Name of Patient:
Given Name Surname Suffix

2. Patient's Occupation at time of Accident:

3. Date & Time of Accident:
Month Day Year Time

4. Place of Accident:
Name of Street/Highway City or Municipality Province

5. Describe fully the nature and extent of the injury/ies sustained.

6. Date and Place you first attended to the patient?

Month	Day	Year	Place

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

Duration	Month	Day	Year
From			
To			

8. If confined, state period of confinement in hospital:

Duration	Month	Day	Year
From			
To			

9. Name and address of hospital:

Name of Hospital	Address

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

11. Is any surgical operation contemplated or had been performed? If so

What? _____

When? _____

Where? _____

By whom? _____

12. a. Was patient suffering from any disease, illness or abnormality independently of his injuries sustained? If so, please provide details:

Nature of abnormality or illness	Date					
	From			To		
	Month	Day	Year	Month	Day	Year

12. b. Did the patient himself give the above information? If not, who gave the information and what is his relationship to the patient?

12. c. Did the abnormality, disease or illness contribute to the occurrence of the accident or retard in any way the patient's recovery from the accident? If so, how and to what extent?

13. a. Was patient, in your opinion, under the influence of liquor, any Intoxicating drink or drug at the time of the accident?

13. b. If he was, what caused you to believe this? Please give particulars.

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

15. What is the prognosis?

I, _____ hereby certify that the answers given above are full, complete
(Physician's Full Name)
and true, I am a graduate of _____ in the year _____.

_____ **Signature of Insured/Beneficiary**

_____ **Physician's Printed Name & Signature**

_____ **Date Signed**

_____ **Date Signed**

_____ **Name and Signature of Witness**

_____ **Name and Signature of Witness**

SUBSCRIBED AND SWORN to before me this _____ day of _____ 20 , by the above claimant who exhibited to me his/her Govt. issued ID/Passport No. _____ , issued at _____ on _____.

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

NOTARY PUBLIC
My Commission expires on _____

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code.)