PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - CRISIS COVER (Stroke)

Name of the Patient (Last name, First name, Middle name) | **Date of Birth**

The above person is insured with Pru Life Insurance Corporation of U.K. against the happening of certain contingent events associated with their health. A claim has been submitted in connection with their insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

- **Instruction : To be accomplished by each attending physician**

A. General

QUESTIONS	YES NO	PLEASE GIVE DETAILS TO "YES" ANSWERS
1. Are you the patient's usual attending physician? If yes, over what period do your records extend?	☐ ☐	
2. When were you first consulted for this condition, and at that time, how long had symptoms been present?		
3. Has the patient previously suffered from the condition specified above or any possible related illness? If yes, please give dates of consultations and resulting diagnosis.	☐ ☐	
4. On which date did the patient become aware of the condition?		
5. Is there anything in the patient's family history which would have increased the risk of experiencing stroke? Please describe.		
6. Please give details of the patient's habits in relation to cigarette smoking.		

B. Medical Details

1. Please provide dates with full and exact details of the diagnosis.		
2. Is there an evidence of a permanent neurological deficit? Please describe.		
3. Is illness directly or indirectly contributed by a) Pregnancy or child birth b) Miscarriage or abortion c) Psychiatric disorders d) Drug or alcohol abuse	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

NAME OF THE PATIENT : _____

Last Name, First Name, Middle Name

4. Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition.	
Name	**Address**

C. Other Information

1. If there is any further information which, in your opinion, will assist us in assessing the claim, please give details.	

DECLARATION
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION
I further authorize the medical director of Pru Life Insurance Corporation of U.K. or any of its authorized representatives or other person in its employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

PURPOSE STATEMENT
We will process the information you have provided in this form for the purpose of handling your patient's request in accordance with applicable privacy laws and regulations. During processing, we may share the information you provided to our authorized data processors, including couriers and contractors for anti-money laundering systems, photocopying, scanning, indexing and printing services. We may share any information provided with governmental and other regulatory authorities, or self-regulatory bodies in various jurisdictions as required or allowed by applicable laws and regulations. Any information collected may be retained by Pru Life UK and our authorized data processors until ten (10) years from the date of termination of the policy.

You may revisit our privacy policy through our website at (https://www.prulifeuk.com.ph/en/footer/privacy-policy/). For data privacy concerns, please contact our Data Privacy Officer at: Telephone: (632) 8887 5433 for Metro Manila, 1 800 10 7785465 via PLDT landline for domestic toll-free Email: dpo@prulifeuk.com.ph

_____ Signature Over Printed Name of the Attending Physician

_____ Specialization

_____ Date

Address : _____
License No: _____