

## I-Heal

## INSTRUCTIONS TO CLAIMANT:

- 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.)
- The following must be submitted, along with this form:
  - 2.1. Insured's Statement of Claim (I-Heal Claim Sickness Form I), asapplicable; 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.
- 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:	(Surnama)	(Cuffix)
2.	(Given Name) Patient's Occupation:	(Surname)	(Suffix)
3. I	Describe fully the nature of the illness.		
4.	Date first symptoms were discovered:		
	Date of first examination/treatment:		
5.1	l. What treatment/s, special examinations and/or proc Please give full details stating the nature of treatmer		
5 ′	2. If confined, state period/s of confinement and name	and address of hospitals	
J.,	From To	Name of Hospital	Address of Hospital
5.3	3. Was any surgical operation performed? If so, please Nature of operation:	provide the following details:	
	Date of operation:		
	Place:		
	Physician/Doctor who performed the operation:		
6. V	What is/are your final and complete diagnosis?		
			_
7 \	Mhat is the pregnesic?		
/. v	What is the prognosis?		

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When	8. Have	you previous	sly attended to the patien	t? If so,				
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, liness 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?  It is a supplementation of the patient is recovery from his/her illness? If so, how and to what extent?  Physician's Full Name)  Physician's Printed Name & Signature  License No.  Valid untit  Tata Signat  Name and Signature  Valid untit  To  SUBSCRIBED AND SWORN to before me this_day of 20, by the above claimant who exhibited to me his/her government issued it/Passport. No.  Bos. No.  Page No.  Doc. No.  Page No.  10. Doc. No.  Page No.  11. Suid at, by the above claimant who exhibited to me his/her lissued at, on					Ear \ \ / b	<b>&gt;</b> +		
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