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 • Website: www.insularlife.com.ph
Tel.: (632) 582-1818 • Fax: (632) 771-1717 • TIN 000-464-124 Non-VAT

# 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: _____
Givename 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? _____