Generali Life Assurance Philippines, Inc.
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ATTENDING PHYSICIAN'S STATEMENT – HOSPITAL INCOME BENEFIT

Note: Kindly submit this form to Generali Life Assurance Philippines, Inc., (GLAPI) duly completed by a qualified and registered physician at the expense of the claimant.

PATIENT'S DETAILS

Last Name	First Name	Middle Name
Address		

Date of Birth (MM/DD/YYYY)	Place of Birth	Age	Status
How long have you known the patient?			
When did the patient first consult you for the present condition?			
Please state the date symptoms were noticed and describe in detail			

DETAILS OF HOSPITAL ADMISSION

Date admitted in the hospital	Date of Discharge	No. of Days
Final Diagnosis		
Date of diagnosis	What is the prognosis?	
When is the patient expected to return to work?		

PLEASE GIVE DETAILS OF THE PATIENT'S PREVIOUS CONDITIONS FOR WHICH YOU ATTENDED PRIOR TO LAST ILLNESS/INJURY:

Date of Attendance	Diagnosis	Treatment/Procedure

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the claim.

I HEREBY CERTIFY that the above statements are true and complete to the best of my knowledge and belief.

Dated at_____ this _____ day of _____ 20_____.

SIGNATURE OVER PRINTED NAME OF PHYSICIAN

QUALIFICATION

ADDRESS

CONTACT DETAILS