THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY
Manila, Philippines

ATTENDING PHYSICIAN'S STATEMENT **TOTAL DISABILITY BENEFITS**

By giving full and complete answers, the Attending Physician will assist the Company in passing promptly on the claim. This statement to be furnished without expense to the Company.

1. Full name of Insured / Payor	2. Where is Insured/Payor now located? (If an inmate of a hospital or other institution give name and address
3. How long have you been Insured's/Payor's medical advisor ?	4. When did Insured's/Payor's health first become effected?
5. Give Symptoms, Diagnosis and Prognosis of Disability	
6. (a) Is Insured/Payor wholly disabled and prevented from engaging in any business or occupation whatsoever?	6. (b) If he is, from what date, to your knowledge, has he been so prevented?
7. (a) Date of your first visit or prescription in present affliction (Month) (Day) (Year)	7. (b) Date of your last visit or prescription in present affliction (Month) (Day) (Year)
8. Is Insured/Payor now confined to his bed or house? State which_____and from what date? (Month) (Day) (Year)	9. When, in your opinion, may Insured be expected to do any kind of work?

10. Have you, or any other physician or practitioners, attended or treated Insured/Payor for any cause whatsoever prior to present affliction?

a. Nature of diseases or injuries?	b. Date of Attendance? From	To	c. Name of Physician or Practitioners	d. Addresses

11. Has Insured/Payor ever received treatment for specific disease? If so, give particulars.

12. Has any member of Insured's/Payor's family or any person in his immediate household ever been afflicted similarly? If so, who?

Additional Remarks	If heart is involved, what laboratory test have been made? Pulse _____ Irregular_____ Blood pressure S_____ D_____

_____ *M.D.*
Physician's signature over printed name

_____
(Address)

_____ *M.D.*
Physician's signature over printed name

_____
(Address)

Form No. D-10

STATEMENT No. 2