PIONEER®
YOUR INSURANCE

CONFIDENTIAL MEDICAL CERTIFICATE
TOTAL & PERMANENT DISABILITY

The Company makes no admission of liability or waiver of rights by furnishing this form.

Patient's Full Name	Date of Birth	Occupation

The person named above is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with Total & Permanent Disability and to enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

1. GENERAL

a. Are you the patient's usual medical attendant? ☐ Yes ☐ No. If "yes", over what period do your records extend?

b. When were you consulted for this condition and, at that time, how long had symptoms been present?

c. Has the patient previously suffered from the condition specified above or any related illness? ☐ Yes ☐ No
If "yes" , please state the dates of consultations and resulting diagnosis.

d. Date the patient first became aware of the condition

e. Date of first treatment for the injury/sickness sustained

f. Date of the most recent examination

g. Was the injury /sickness sustained in an accident? ☐ Yes ☐ No

h. Was the injury /sickness related to or a result of his/her occupation? ☐ Yes ☐ No

Please give details:

2. MEDICAL DETAILS

a. Please provide the full and exact details of the diagnosis. Please specify the affected body parts, organ, system.

b. What restrictions have you placed on the patient's activities?

c. What was/were the cause/s of the disease/s?

d. Is the Insured totally incapacitated from engaging in any occupation for compensation or profit or performing the normal activities of life? Please elaborate.

☐ Yes ☐ No

If "yes", from what date has he/she been incapacitated and up to when?

e. Was this period uninterrupted/continuous or not? Please elaborate.

f. Prognosis

(i) Has the patient's condition stabilized? ☐ Yes ☐ No

(ii) Has the patient reached maximum medical improvement? ☐ Yes ☐ No If "yes", state the date when it improved.

(iii) Is the patient a candidate for rehabilitation?

Additional Comments:

g. Has this type of illness been confirmed by specialist investigation? Please give details of special or ancillary procedures done as well as laboratory evidence. Kindly provide copies of these tests.

h. Physical & /or Mental Impairment

- ☐ No limitation; may return to work
- ☐ Slight limitation; capable of light work
- ☐ Moderate Limitation; Capable of Sedentary Work
- ☐ Cannot perform present work but capable of performing another line of work
- ☐ Temporary limitation of functional capacity; temporarily incapable of any kind of work
- ☐ Severe limitation of functional capacity; permanently incapable of any kind of work

i. If the limitation is temporary, when should the patient be able to return to work?

Full time : _____

Part time :_____

j. Please comment if the patient is able to perform without assistance his/her Activities of Daily Living. Please specify which, among the six (bathing, dressing, using the lavatory, eating, ability to move in or out of a bed or chair, ambulatory), he/she is able to do alone.

k. Please give the name(s) and address(es) of all consultants, specialists or hospitals to which your patient has been referred or attended to for this condition.

3. OTHERS

If there is any further information which in your opinion will assist our Medical Consultant in assessing this claim, please give details.

Please provide copies of any relevant hospital reports/records which are available.

Date Today	Physician's Signature Over Printed Name	
Address	Tel. No.	License No.

Authorization To Release Information:

I/We hereby authorize **Pioneer Life Inc.**, its reinsurers and/or its duly authorized representatives to collect, retrieve, use and/or otherwise process from any government or private hospitals, offices or any other personal information, controllers and processors who collects, holds, processes or uses any of my and the named insured's personal information, and for any of the latter to furnish Pioneer Life Inc., its reinsurers and/or its duly authorized representatives with, any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to any of my and the named insured's personal information. This authorization is being made in connection with any claim on the insurance policy or policies issued by the insurance company on the life of the abovementioned Insured. It is understood that any action of any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controllers and processors who collects, holds, processes or uses any of my personal information may take in connection with this authorization releases said persons or entities or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

I/We hereby certify that I/We have carefully read and clearly understood the terms of the above said authorization, and do hereby voluntarily accept and acknowledge the same as an informed expression of my own free will.

NOTE: Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

I / We hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I / We understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the Policy shall be void and all the rights to recover thereunder in respect of past or future claims shall be forfeited.

_____	_____
Signature over Printed Name of Claimant/Beneficiary	Signature over Printed Name of Attending Physician
Date: _____	Date: _____