PIONEER®
YOUR INSURANCE

CONFIDENTIAL MEDICAL CERTIFICATE TERMINAL ILLNESS

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

Name	Date of Birth	Policy No.

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 Terminal Illness and to enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

MEDICAL HISTORY

1. Are you the patient's usual medical attendant? ☐ Yes ☐ No
   If "no", please provide the name and address of his usual/other medical attendant/s.

2. Please state below how long you have known the patient on a professional basis and provide the dates of the first and last consultation based on your records.

3. What is the complete diagnosis of the patient? When were you first consulted for this disease and, at that time, how long have the symptoms been present?

4. Kindly list the follow ups and findings, treatment and other pertinent data during the follow ups.

5. Please describe the full and exact details of the diagnosis. Kindly attach reports of any related investigation done such as biopsy reports, cytology reports, CT scans or any other imaging studies and blood chemistries, etc.

   a. What was the site or the organ involved? ______________________

   b. What is the histological diagnosis of the disease? ______________________

   c. What is the stage of the disease? Please describe using appropriate staging classification? ______________

   d. Was the lesion completely localized? ☐ Yes ☐ No
   e. Was there invasion of adjacent tissue? ☐ Yes ☐ No
   f. Were lymph nodes involved? ☐ Yes ☐ No
   g. Were there metastases? ☐ Yes ☐ No
   h. Is the disease associated with AIDS or HIV infection? ☐ Yes ☐ No

6. Is the condition a result of or caused directly, wholly or partly, by:
   a. any attempt at self-destruction while sane or insane? ☐ Yes ☐ No
   b. addiction to alcohol or drugs not prescribed by a medical doctor? ☐ Yes ☐ No
   c. poison, gas or fumes (voluntarily or involuntarily taken), atomic or nuclear radiation? ☐ Yes ☐ No
   d. acquired immune deficiency syndrome (AIDS) or presence of any human immunodeficiency virus (HIV)? ☐ Yes ☐ No

7. What is the nature of the treatment?

☐ Surgical ☐ Chemotherapy ☐ Radiotherapy ☐ Palliative ☐ Others ☐ Please provide details of procedure(s).

8. Predicted Survival Period (Life Expectancy)

Attendant/Precipitating/Aggravating conditions:

9. Has the patient previously suffered from any related illness? ☐ Yes ☐ No
If "yes", please provide the dates of consultations and the resulting diagnosis.

10. Is there any relevant condition in the patient's family history which would have increased the risk of the disease?
☐ Yes ☐ No If "yes", please give details.

11. Please give details of the patient's habits in relation to cigarette smoking, drinking habits, lifestyle, usual diet, etc. that may have contributed to his/her present illness.

Please provide copies of any relevant hospital reports/records report 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: ______