ATTENDING PHYSICIAN STATEMENT

Sun Life Assurance Company of Canada Singapore Branch

Sun Life

PLEASE PROVIDE COPIES OF ALL MEDICAL RECORDS AND TEST RESULTS TOGETHER WITH THIS STATEMENT.

1.	Name of Patient as appears on ID / Passport	
2.	ID/Passport Number of Patient	
3.	When did you first see this Patient (dd/mm/yyyy)	When did you last see this Patient (dd/mm/yyyy)

4. Please provide the following detail from this Patient's last consultation

Height (centimeters)	Weight (kilograms)	Blood Pressure	Tobacco Use
			☐ Yes ☐ No

5. Please provide details of all consultations in chronological order starting from the last consultation

Date of Consultation (dd/mm/yyyy)	Reason for Consultation (complaint, symptoms, organ(s), frequency/severity)
Details (diagnosis, cause, tests, complications, hospitalization, if recovered, etc.)	
Treatment Plan (testing, medication, referral, follow up, surgery, etc.)	
Date of Consultation (dd/mm/yyyy)	Reason for Consultation (complaint, symptoms, organ(s), frequency/severity)
Details (diagnosis, cause, tests, complications, hospitalization, if recovered, etc.)	
Treatment Plan (testing, medication, referral, follow up, surgery, etc.)	

Date of Consultation (dd/mm/yyyy)	Reason for Consultation (complaint, symptoms, organ(s), frequency/severity)
Details (diagnosis, cause, tests, complications, hospitalization, if recovered, etc.)	
Treatment Plan (testing, medication, referral, follow up, surgery, etc.)	

6. Please provide details of all test results in chronological order starting from the last test done

Date of Test (dd/mm/yyyy)	Test (blood test, CT, MRI, echo, angiogram, endoscopy, ultrasound, biopsy, etc.)
Reason	
Results / Findings	
Date of Test (dd/mm/yyyy)	Test (blood test, CT, MRI, echo, angiogram, endoscopy, ultrasound, biopsy, etc.)
Reason	
Results / Findings	
Date of Test (dd/mm/yyyy)	Test (blood test, CT, MRI, echo, angiogram, endoscopy, ultrasound, biopsy, etc.)
Reason	
Results / Findings	

7. List of all the medication (s) that this Patient is currently taking

Name	Dosage	Frequency	Reason

8. Please provide details of present conditions (include sequelae and complications of reported illnesses)

9. Have any other physicians or surgeons been consulted or recommended? ☐ Yes ☐ No
If "Yes," please provide the physician or surgeon's name, clinic / hospital, address, date and reason for consultation

10. Please provide any other information which might have a bearing on this Patient's health

11. Is this Patient now in good health? ☐ Yes ☐ No
If "No," please explain

SIGNATURES

The information obtained in this Attending Physician Statement (the "Statement") is required in order for Sun Life Assurance Company of Canada Singapore Branch (the "Company") to consider the insurability of the person examined by the attending physician, in respect of a proposed life insurance Policy that insures the life of the said person (the "Policy"). By signing below, the attending physician confirms that the information provided in this Statement are complete, true and correct. The attending physician hereby consents to the collection, use, storage, transfer and disclosure by the Company of his or her Personal Data (as defined in the Personal Data Protection Act 2012) contained in (or included with) this Statement for the purposes of the Policy.

Physician's Signature	Date (dd/mm/yyyy)
Surname / Family Name / Last Name of Physician	
Given Name / First Name of Physician	
Current Specialty	Medical License Number
Practice Address	

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