COCOLIFE
UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION
COCOLIFE Building 6807 Ayala Avenue Makati City 1226
Tel. No. 8812-9015 • Website: www.cocolife.com

DATE:

_____
_____
_____

Attending Physician : **Dr.** _____

Subject : **AUTHORIZATION TO MY ATTENDING PHYSICIAN**
Name of Patient:
Date of Birth:

I, _____ with address at _____ your patient, has applied for an insurance coverage to **United Coconut Planters Life Assurance Corporation ("Cocolife").** By reason of this, I hereby give you my consent to the access and sharing of my medical records and history, physical or laboratory findings and conclusion to Cocolife for purposes of evaluating my insurance application.

A summary, as outlined on the reverse side, would be helpful for the accomplishment of the declared purpose. Further, as data subject, I grant my free, voluntary and unconditional consent to Cocolife for the collection, processing, use, access, storage of all personal data on the account of the above – mentioned request.

As a patient and applicant, I will release, waive and forever discharge you and Cocolife, its officers, agents, and employees, all its successors and assigns from any and all action or other obligations arising from or in connection with the above – mentioned request, and hold harmless and keep you and the corporation, Cocolife, fully indemnified against all costs, expenses, losses, damages, claims in connection with the herein request.

Thank you for your prompt attention on this request.

Sincerely,

_____
Name and Signature of Patient/Applicant

Endorsed by:

ANNA KARMELA O.SO, M.D.
Medical Director - Cocolife

Fee: Php_____

UNDG-019-1219-6

Applicant: _____

Re: _____

ATTENDING PHYSICIAN'S STATEMENT-UNDERWRITING INFORMATION

Dates Attended		Complaints & Abnormal Physical Finding	Duration of Illness	Diagnosis	Describe Treatment or Operation
MONTH	YEAR				

(2) Laboratory Findings (including x-ray, ECG, and pathological reports, etc., with dates)

Most recent serum cholesterol level _____ Date _____
Most recent triglyceride level _____ Date _____

(3) Present condition, if known ? (include sequelae and complications of above-reported illnesses)

(4) Have any other physicians or surgeons been consulted ? if so, please give name, date and nature of disorder.

(5) Please record any other information which might have a bearing on this person's health.

(6) To the best of your knowledge, does this person now smoke cigarettes? Yes ☐ No ☐
If "No", has this person ever smoked cigarettes? Yes ☐ No ☐

Date . . . . . (Signature) . . . . . M.D