INSULAR LIFE HEALTH CARE, INC.

2/F I-Care Bldg., 167 Legaspi St., Legaspi Village
City of Makati 1229
Tel. No. 813-01-31 to 39 Fax No. 813-79-03

CLAIMS MEDICAL CERTIFICATE

Patient: _____ ID No.: _____
Hospital/Clinic: _____ Treatment Date: _____
Diagnosis: _____

Nature of Services : ( ) Consultation ( ) In-Patient ( ) ER Services ( ) Others
Brief Clinical History:

_____
_____
_____
_____
_____

Treatment/procedures performed:

_____
_____

I swear on my professional oath to the truth of all my foregoing statements.

PRINTED NAME OF PHYSICIAN	LICENSE NUMBER	SIGNATURE OF PHYSICIAN
ADDRESS		DATE