Does the Insured show signs and feel symptoms of Leptospirosis like:

High Fever

Jaundice
(yellow skin and eyes)

Headaches

Body Pain

Follow these steps:

1. Consult a licensed physician and take the necessary diagnostic tests.
2. Ask the licensed physician to accomplish and sign the CLAIMS MEDICAL REPORT (CMR) below.
3. If the licensed physician confirms the diagnosis as Leptospirosis with the signed CMR, submit it with the diagnostic test results to Pioneer by:
   a. Scanning and sending via email to PLI_OpsClaims@pioneer.com.ph
   b. Taking a picture and sending via Viber to 0917 531 7213
   c. Delivering the hard copies to any Pioneer branch

CLAIMS MEDICAL REPORT (LEPTOSPIROSIS)

To be filled out by the attending physician

In order for the claim to be valid, the following definitions must be fulfilled:

Leptospirosis. An infection disease caused by the spirochete Leptospira interrogans bacteria transmitted by rats and other vermin. This is characterized by fever, headache, muscle pain, jaundice and in severe cases, involving the liver, kidney and the lungs.

Physician. A person legally licensed to practice medicine and/or perform surgery in the Philippines and must not be the Insured himself nor any member of his immediate family: parents, spouse, children, and siblings.

Name of Patient: _____

Address: _____

Diagnosis: _____

1. Are you the patient's usual medical attendant? ( ) Yes ( ) No.
   Please state how long you have known the patient and provide the dates of the first and last consultation:

_____

(Continuation of Medical Report)

Are you related to the patient? ( ) Yes ( ) No. If yes, how?

_____

_____

2. Please write out the History of Present Illness and your Physical Examination Findings:

_____

_____

_____

3. What were the laboratory tests or ancillary procedures done? What are the results? Please attach a copy of the results to this Medical Report.

_____

_____

_____

4. Has the patient previously suffered from the condition specified above? ( ) Yes ( ) No. If "Yes", please state dates of consultation and resulting diagnosis.

_____

_____

_____

5. In your opinion, does the condition suffered by the patient fulfill the definition stated above? ( ) Yes ( ) No.

_____

_____

_____

DECLARATION

I hereby certify that the above statements and facts which answer the preceding questions are true and that I have not withheld any material information in connection with the above condition.

Date

_____

Physician's Signature over Printed Name

_____

License Number: _____

Contact No.: _____