

Attending Physician's Statement

THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Reference #:

Policy #:

Patient's name and address:

Sex:

Date of Birth

M

F

What is disabling the patient?

Please give a complete diagnosis of this condition:

HISTORY

When did Patient first receive medical treatment?

Was there a previous history of this or a similar condition? Yes
No

If yes, please state condition and advise when previous treatment was given:

How long have you known the patient?

Are you their regular general practitioner? Yes
No

If no, please advise who is:

IF INJURY:

When did patient suffer the injury?

What were the circumstances surrounding the injury?

IF SICKNESS:

When was sickness first contracted?

When did the symptoms become evident?

DEGREE OF DISABILITY:

Patient's occupation:

When was patient obliged to cease work?

If patient is still disabled, when approximately will the patient be able to resume:

a. Some duties:

b. Most duties:

OR

If patient has recovered, when was patient able to resume:

a. Some duties:

b. Most duties: