

Attending Physician's Statement Total and Permanent Disability Claim

NOTE: Fill out with block letters.

Put on the tick boxes representing options.

Please use reverse side for answers requiring additional information but not indicated on this questionnaire.

Identify your answers with the corresponding numbers.

PATIENT'S INFORMATION

Name:

<i>Last Name</i>	<i>First Name</i>	<i>Middle Name</i>
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Address:

Occupation:

Gender: Male Female

Date of Birth:

mm / dd / yyyy

Height:

Weight:

MEDICAL HISTORY

1. Are you the insured's regular physician? Yes No

2. How long have you known the injured for his/her present illness/injury?

3. When did you first attend to the insured for his/her present illness/injury?

mm / dd / yyyy

4. Have you previously attended to the insured? Yes No

If yes, please describe below.

When	For what
<i>mm / dd / yyyy</i>	
<i>mm / dd / yyyy</i>	

5. Has the insured been treated by any other physician? Yes No

If yes, give their names and addresses.

Name of Physician	Address	Date	Nature of Disease
		<i>mm / dd / yyyy</i>	
		<i>mm / dd / yyyy</i>	

MEDICAL HISTORY *Continuation*

6. Has the insured received treatment in any hospital, sanitarium or institutions? Yes No

If yes, state where.

Name of Hospital	Address	Date	Treatment Received
		<i>mm / dd / yyyy</i>	
		<i>mm / dd / yyyy</i>	

7. What and when was the earliest indication of illness noted by the injured? Give your basis.

8. When in your opinion, did the illness which directly or indirectly caused the disability commence?

9. Was the insured in good health up to the time of his/her present illness? Yes No

If not, give details.

DISABILITY

10. How would you classify the insured's disability?

Total Permanent Partial Permanent Total Temporary Partial Temporary

If partial, what in your opinion is the degree of incapacity?

11. If totally disabled, since when?

mm / dd / yyyy

12. Is the injured totally disabled now? Yes No

DIAGNOSIS

13. What is your diagnosis?

Interpretation, if any, of:

(a) Laboratory reports:

(b) X-ray:

(c) Electrocardiogram:

14. Was there any predisposing or contributing cause, remote or recent, for the present disability in the family history, occupation or previous illness of the insured? Yes No
If yes, describe fully.

15. Is any surgical procedure/operation contemplated on or has one been performed? Yes No
If yes,

What	When	Where	By whom
	<i>mm / dd / yyyy</i>		
	<i>mm / dd / yyyy</i>		
	<i>mm / dd / yyyy</i>		

PROGNOSIS

16. What is the prognosis?

17. When, in your opinion, can the insured resume his/her usual occupation or employment?

PHYSICIAN'S DECLARATION

I, *Physician's Name in Full: Last Name, First Name, Middle Name*

a graduate of *Medical College*

in the year with License No.

hereby truthfully certify that the answers given above are full, complete and true.

Witnessed by:

Physician's Signature

Printed name and signature of witness

Date Signed: *mm / dd / yyyy*

Place Signed:

Mobile Number: *{09XX-XXXXXXX}*

Clinic Address:

Clinic Hours: