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Attending Physician's Statement Major Disease/Critical Illness Blindness

Pati	ient's Name						
Atte	ending Physician's Name	Address					
This	s section must be completed by a qualified and regis	stered physician at the expense of the claimant.					
bee		of certain contingent events associated with his/her health. A claim has le us to assess the claim, we would be grateful for your cooperation in					
Α.	GENERAL INFORMATION						
1.	Are you the patient's usual medical doctor?	Yes No					
	If yes, over what period do your records extend to?						
	Start date////	y End date//// yyyy					
2.	When did the patient first consult you for this condition						
3.	Please state symptoms presented and date symptoms first appeared.						
	Symptoms Presented at First Consultation	ate Symptoms First Started (DD/MM/YYYY)					
4.	What / Who is the source of this information?						
_							
5.	oid the patient consult any other doctors for these symptoms before he/she consulted you? Yes No iyes, please provide details below.						
	Name of Doctor	Name of Clinic/ Hospital and Address					

B. DETAILS OF DISEASE / MAJOR CRITICAL ILLNESS

(b)	Date of onset	dd	/	mm	/	уу		
(c)	Date of diagnosis	dd	/	mm	/	уу		
(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.							nade.	
	Name of Doctor				Name of C	Clinic/ Hos	spital and Add	ress
(d) Date when patient was first made aware of the diagnosis?//								
(e)	Was the patient admitted in the		tilo did	.g.10010 .		′ Yes	////	
,	If yes, please provide the following details. ame / Address of Hospital							
	Date of Admission		Date	e Discharge	ed		No.	of Days
(a)	Please describe the extent of BI	indness.						
(b) Do you consider the Blindness as total and irreversible loss of all sight of both eyes? If yes, please provide basis for details.				N				

10.	Please provide full details of tests and results which have been performed to establish the diagnosis of Blindness, and attact copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.						
11.	Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of doctors consulted.						
	Name of Doctor	Name of Clinic/ Ho	Name of Clinic/ Hospital and Address				
C.	MEDICAL HISTORY						
12.	Has the patient previously suffered from the condition specified above or any related illnesses?						
	yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending lease state source of information.						
	Date of Consultation	Name of Doctor / Address	Diagnosis				
3.	Is there anything in the patient's medical history which would have increased the risk of Blindness?						
	Yes	☐ No					
	If yes, please provide details including the date of consultations, their resulting diagnosis, name and address of attendin doctor. Please state source of information.						
	Date of Consultation	Name of Doctor / Address	Diagnosis				
14.	Please give details of the patient's fam nature of illness, date of diagnosis) Ple	ily history which would have increased the risk case state source of information.	of Blindness (including the relationship,				

15. Please give details of the patient's habits in relation to past and present smoking, including the duration of sm number of cigarettes smoked per day. Please state source of information.							
16.	Please give details of the patient's habits in relation to alcohol consuday. Please state source of information.	mption, including the amou	nt of alcohol consumption per				
17.	Does the patient have or ever had any other significant health condition. If yes, please provide details of the condition, including diagnosis, received.		No of condition(s) and treatment				
18.	A ITIONAL INFORMATION Please provide us with any other additional information that will enable the Company to assess this claim.						
I he	ereby certify that the above statements are true and complet	te to the best of my kno	wledge and belief.				
	Name of Attending Physician (Please print)	Degree/S	pecialty				
	Signature	Date Sign	ed				
	PRC Number / PTR Number	Telephone	Number (s)				

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.