

**PHYSICIAN'S STATEMENT**  
**Claim under the Disability Waiver Certificates**

NOTE : Please use reverse side for answers requiring additional information not called for in this questionnaire. Identify your answers with corresponding item numbers.

**CLAIMANT:**

1. Name	
2. Address	
3. Occupation	4. Apparent Age
5. Height	6. Weight

**MEDICAL HISTORY:**

7. Are you his regular physician?	
8. How long have you known him?	
9. When did you first visit him for his present illness?	
10. Have you previously attended him? If so	
WHEN?	FOR WHAT?
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11. Has he been treated by any other physician? If so, give their names.	
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12. Has he received treatment in any hospital, sanitarium or other institution? If so, state where.	
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13. What and when were the earliest indications of illness noted by the insured? Give your basis.	
14. When in your opinion did the illness which directly or indirectly caused the disability commence?	
15. Was he in good health up to the time of his present illness? If not, give details.	

**DISABILITY:**

16. How would you classify his disability?

- Total-Permanent                       Total Temporary  
 Partial-Permanent                       Partial-Temporary

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

%

17. If totally disabled, since when?

~~18. Is he now totally disabled?~~

**DIAGNOSIS:**

19. What is your diagnosis?

Interpretations, if any, of Laboratory reports:

X-ray:

Electrocardiograms:

~~20. 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? If so, describe fully.~~

21. Is any surgical operation contemplated or has one been performed? If so,

What? -----

When? -----

Where? -----

By whom? -----

**PROGNOSIS:**

22. What is the prognosis?

I, \_\_\_\_\_ hereby certify  
 (Physician's name in full)  
 that the answers given above are full, complete and true, I  
 am a graduate of \_\_\_\_\_ in the year \_\_\_\_\_.  
 (Medical College)

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Address in full

\_\_\_\_\_  
 Signature of the insured                      Date  
 (must be signed in the presence of the Attending Physician)