

CERTIFICATE OF ATTENDING PHYSICIAN
DISABILITY CLAIM FORM NO. 2

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

POLICYHOLDER : _____ MASTER POLICY NO. _____

1. Full Name of Insured : _____ Certificate No. _____

2. Present Address : _____ 3. Age _____

4. Occupation : _____ 5. Height _____ 6. Weight _____

7. Are you his/her regular physician ? _____ 8. How long have you known him ? _____

9. Have you previously attended him? If so,

W H E N

FOR WHAT

10. Has he/she been treated by any other physician? If so, give their names and addresses.

NAME OF PHYSICIAN

ADDRESS

11. Has he/she received treatment, in any hospital, sanitarium or other institution? If so, state where.

12. What and when were the earliest indications of illness noted by him/her. Give your basis.

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

14. Was he/she in good health up to the time of his/her present illness? If not, give details. _____

15. How would you classify his/her disability? () Partial-Temporary () Partial-Permanent

() Total-Permanent () Total Temporary
If partial, what in your opinion, is the degree of incapacity ? _____

16. If totally disabled, since when ? _____

17. Is he/she not totally disabled ? _____

18. What is your diagnosis ? _____

Interpretations, if any, of Laboratory reports : _____
X-ray : _____ Electrocardiograms : _____

19. 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. _____

CERTIFICATE OF ATTENDING PHYSICIAN / DISABILITY CLAIM FORM NO. 2

20. Is any surgical operation contemplated or has one been performed? If so,
What? _____
When? _____ Where? _____
By whom _____
21. What is the prognosis? _____
22. When in your opinion, can he/she resume his/her usual occupation or employment?

I, _____ hereby certify that the answers given above are
(Printed Name of Physician)
full, complete and true. I am a graduate of _____ in the
(Medical College)
year _____ .

Dated and signed at _____ on _____, _____ .

FULL ADDRESS OF PHYSICIAN

PHYSICIAN'S SIGNATURE

PTR No. _____

Date Issued _____

Place of Issue _____

SIGNATURE OF INSURED
(Must be signed in the presence of the
Attending Physician)