ATTENDING PHYSICIAN'S STATEMENT
CONTINUANCE OF TOTAL DISABILITY

AIA HEALTHIER, LONGER, BETTER LIVES

Please fully accomplish this form to facilitate processing of your claim. Any expense/s incurred on the issuance of this statement shall be borne by the Insured / Payor.

1. Full name of Insured / Payor	2. Where is the Insured/Payor now located? (If confined in the hospital or other institution, pls. give name and address.
3. How long have you been Insured's/Payor's medical advisor ?	4. When did the Insured's/Payor's health first become effected?

5. Pls. give Symptoms, Diagnosis and Prognosis of Disability

6. (a) Is Insured/Payor wholly disabled and prevented from engaging in any business or occupation whatsoever?	6. (b) If he is, from what date, to your knowledge, has he been so prevented?
7. (a) Date of your first visit or prescription in present affliction _____ (Month) _____ (Day) _____ (Year)	7. (b) Date of your last visit or prescription in present affliction _____ (Month) _____ (Day) _____ (Year)
8. Is Insured/Payor now confined to his bed or house? State which_____ and from what date? _____ (Month) _____ (Day) _____ (Year)	9. When, in your opinion, may Insured be expected to do any kind of work?

10. Have you, or any other physician or practitioner, attended or treated Insured/Payor for any cause whatsoever prior to present affliction?

a. Nature of diseases or injuries?	b. Date of Attendance? From To	c. Name of Physician or Practitioner	d. Address/es

11. Has Insured/Payor ever received treatment for specific disease? If so, give particulars.

12. Has any member of Insured's/Payor's family or any person in his immediate household ever been afflicted similarly? If so, who?

Additional Remarks	If heart condition is involved, what laboratory tests have been made? Pulse _____ Irregular_____ Blood pressure S_____ D_____

_____ M.D.
Physician's signature over printed name

_____
(Address)

_____ M.D.
Physician's signature over printed name

_____
(Address)