



ATTENDING PHYSICIAN'S STATEMENT

Continuance of Total Disability

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 _____
--------------------	--

Physician's signature over printed name

(Address)

Physician's signature over printed name

(Address)

