Policy Number

Disability Claim Form
(Attending Physician's Statement)

FOR OFFICE USE ONLY

Date Received:

Time Received:

Receiving Dept./Office:

FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's name:

FE/Advisor's mobile number:

Important Notes:

1. This form is to be accomplished by the Attending Physician.
2. Please write legibly in BLOCK LETTERS. Do not sign on a blank form.
3. Please shade the circle to indicate your choice(s).

1. General Information:

Full Name of the Patient:

Date of Birth: (yyyy/mm/dd)

2. Your Association with the patient:

Are you related to the patient? ◯ Yes ◯ No **If "Yes", please provide details below:**

Relationship:

No. of years you have known the patient

Are you the attending physician of the patient prior/during his/her disability? ◯ Yes ◯ No

If "Yes", please provide details below:

Date when you first attended the patient

Chief complaints of the patient

3. Particulars of the Disability:

Nature of patient's disability:

Cause of disability:

◯ Illness ◯ Accident

Date you have diagnosed the disability:

If disability is due to Illness, please provide details below:

Symptoms of illness during the first consultation:

Date of first consultation:

Duration of the symptoms:

If disability is due to Accident, please provide details below:

Details of injury(ies) sustained:

Date & time of accident:

Place of accident:

Please provide below the details of your diagnosis and the medical treatment/management given to the patient:

Complete diagnosis:

Details of treatment/management:

Prognosis:

How would you classify the patient's disability?

- ◯ Total Permanent Disability
- ◯ Total Temporary Disability
- ◯ Partial Permanent Disability
- ◯ Partial Temporary Disability

Please shade below the Activities of Daily Living (ADL) that the Patient is currently UNABLE to perform without assistance:

- ◯ Ability to feed oneself
- ◯ Ability to get in and out of bed
- ◯ Ability to attend to own toilet needs
- ◯ Ability to dress and/or undress oneself
- ◯ Ability to wash and bath oneself
- ◯ Ability to move from room to room on level surface

Aside from you, did other physicians attend the patient regarding his/her disability?

◯ Yes ◯ No **if "yes", please provide details below:**

Name:

Contact Details:

4. Details of your past consultations on the patient:

Date (yyyy/mm/dd)	Diagnosis	Treatment

5. Declarations:

I hereby certify that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician:

Signature:

Place of Signing:

Date of Signing: (yyyy/mm/dd)

Field of Specialization:

License No:

Clinic Address:

Mobile No.:

Clinic Tel. No.: