



Policy Number

Policy Number input boxes

# Disability Claim Form (Attending Physician's Statement)

### 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:

Full Name of the Patient input boxes

Date of Birth: (yyyy/mm/dd)

Date of Birth input boxes

### 2. Your Association with the patient:

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

Relationship:

Relationship input box

No. of years you have known the patient

No. of years you have known the patient input box

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

Date when you first attended the patient input box

Chief complaints of the patient

Chief complaints of the patient input box

### 3. Particulars of the Disability:

Nature of patient's disability:

Nature of patient's disability input box

Cause of disability:

Illness  Accident

Cause of disability input box

Date you have diagnosed the disability:

Date you have diagnosed the disability input box

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

Symptoms of illness during the first consultation:

Symptoms of illness during the first consultation input box

Date of first consultation:

Date of first consultation input box

Duration of the symptoms:

Duration of the symptoms input box

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

Details of injury(ies) sustained:

Details of injury(ies) sustained input box

Date & time of accident:

Date & time of accident input box

Place of accident:

Place of accident input box

#### FOR OFFICE USE ONLY

Date Received:

Date Received input box

Time Received:

Time Received input box

Receiving Dept./Office:

Receiving Dept./Office input box

#### FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's code input box

FE/Advisor's name:

FE/Advisor's name input box

FE/Advisor's mobile number:

FE/Advisor's mobile number input box

**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.:**