PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - Disability Claim

* Instruction : This form shall be accomplished by each and every Attending Physician on the injury sustained.

The person whose name appears below is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/her insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

Name of the Patient (Last name, First name, Middle name)	**Date of Birth**

Address

# Street					
City/Province		Zip Code		Tel #	

Date of Illness / Accident	**Final Diagnosis**	**Date of Admission**	**Date of Discharge**

A. General

Questions	YES	NO	Please give Details To "YES" Answers
1. Are you the patient's regular Physician? How long has he/she been under your care ?	☐	☐	
2. Please describe fully the illness/injury and its severity			
3. How would you classify the disability? Partial Permanent, Total Permanent, Partial Total Temporary or Partial Temporary ?			
4. Please give the direct cause of the disability			
5. Please indicate approximate date from which the patient first notice symptoms of current condition.			
6. Has the patient been treated previously for this condition? If 'Yes', please state when.	☐	☐	
7. Duration of Illness/Disability. If duration for recovery is more than usual, please explain why.			
8. What is your Prognosis			
9. Is consultation/treatment in connection with this disability related or due to (please indicate date injury/illness was sustained) :			
a. Pregnancy, infertility, sub-fertility or childbirth, abortion? If for pregnancy, what was the approximate date of commencement?	☐	☐	
b. Self-inflicted injury or sexually transmitted disease? If 'Yes', please specify	☐	☐	
c. Congenital anomaly, nervous or mental disorder? If 'Yes', please specify.	☐	☐	
d. Surgery for cosmetic or aesthetic purposes ? If 'Yes', please specify.	☐	☐	
e. Drug addiction or alcoholism ?	☐	☐	
f. Psychiatric disorders ?	☐	☐	
g. a job-related injury? If 'Yes', please specify.	☐	☐	
h. Others, which are not specified above.	☐	☐	

NAME OF THE PATIENT: _____

Last Name, First Name, Middle Name

B. Capabilities of the Patient

a Given the current condition & extent of disability the patient has suffered, when can he/she resume his/her usual occupation?	
b Given the extent of the disability the patient presently has suffered, will it prevent him/her from performing any kind of work outside his/her usual occupation?	
c Given the extent of the disability the patient presently has suffered, which of the following daily activities he/she can not do? (1) continence (2) dressing (3) bathing (4) feeding (5) mobility or transferring in or out of the chair, bed or to walk	

C. If disability was caused by Accident

Questions	YES NO	Please give Details To "YES" Answers
1. Was the patient in good health prior to the injury/Disability? If Not, please give details.	☐ ☐	
2. At the time of the accident/incident, was the patient under the influence of alcohol, illegal drugs?	☐ ☐	
3. Place & Date of Accident		
4. Evidence of any permanent disability the patient sustained as a result of the illness / accident.		

5. Please provide details on any Surgical Operations performed or contemplated on the patient in the table below.

Date	Name and Address of Hospital	Type of Operation

8. Please provide details of any Doctor or Specialist who have been consulted in connection with this condition.

Date	Name and Address	Findings	Duration

DECLARATION

I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION

I further authorize your Medical Director or any of his/her authorized representative or other person in your employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

_____ Signature Over Printed Name of the Attending Physician

_____ Specialization

License No:

Address :

_____ Date