PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT – CRISIS COVER (Muscular Dystrophy)

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

The above person 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 policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. General

QUESTIONS	YES	NO	PLEASE GIVE DETAILS TO "YES" ANSWERS
1. Are you the patient's usual Attending Physician? If yes, over what period do your records extend?	☐	☐	
2. When were you first consulted for this condition?			
3. What were the presenting symptoms?			
4. When did symptoms first present, and how long it had been present?			
5. On which date did the patient become aware of the condition?			

B. Medical Details

1. Please provide dates with full and complete details of the diagnosis			
2. Date patient was informed of the diagnosis.			
3. Please provide dates & other details of investigations performed and attach copies of all relevant laboratory reports.			
4. Please provide details with dates of all operations performed, treatment and medication.			
5. Is illness hereditary?	☐	☐	
6. Has the patient previously suffered from the condition (s) specified above or any related illness? If "yes", please give dates of consultation (s) and the resulting diagnosis.	☐	☐	
7. Please provide complete name and address of all Consultants, Specialists or Hospitals to which your patient has been referred or attended for this condition.			
8. Is Patient HIV (Human Immuno-Deficiency Virus) positive? If so, please provide details including the date of diagnosis.	☐	☐	

NAME OF THE PATIENT : ______________________________

Name, First Name, Middle Name

9. Please provide details of patient's personal and family medical history.	
10. Please give details of the patient's habits in relation to cigarette smoking.	

C. Other information

1. Did the illness permanently prevent the insured from performing activities of daily living without assistance?	
2. If Yes, please mark the type of activity the patient is unable to perform without assistance. [ ] Dressing [ ] Bathing [ ] Eating [ ] Using the Lavatory [ ] Mobility – Does the patient use support devices to move? [ ] YES [ ]NO If Yes , Please specify ______________________________ [ ] Transferring ex: moving in and out of bed or chair	
3. What is the prognosis?	
4. Is there any further information, which, in your opinion, will assist us in assessing the claim?	

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

____
Date

License No :

Address :