PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - CRISIS COVER *(Heart Valve, Coronary Artery Bypass or Aortal Surgery)*

Name of 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 insurance 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" ANSWER
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, and at that time, how long had symptoms been present?		
3. Has the patient previously suffered from the condition specified above or any possible related illness? If yes, please give dates of consultations and resulting diagnosis below	☐ ☐	

Date Consulted	Hospital/Clinic	Name of Attending Physician	Diagnosis

4. On which date did the patient become aware of the condition?	

B. Medical Details

1. Please provide dates with full and exact details of the diagnosis.	
2. What type of surgery or procedure did the patient undergo?	
3. What is/are the predisposing factor/s contributory to the illness of the patient? Please give exact details on the history of such illness.	

4. Please give below the name and address of all Consultants, Specialists or Hospitals to which the Patient has been referred or attended for this condition.

Name of the Attending Physician	Address	Dates Attended	Diagnosis

5. What is your prognosis?	

NAME OF THE PATIENT : ______________________________

Last Name, First Name, Middle Name

C. Other Information

1. If there is any further information which, in your opinion, will assist us in assessing the claim? Please give details.	

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

Address : ______________________________

License No: ______________________________