PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - Crisis Cover (Major Organ Transplant)

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

The above 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.

*** Instruction : This form shall be accomplished by each and every Attending Physician who diagnosed the patient of the illness sustained.**

A. General

1. Are you the patients usual Attending Physician? If yes, over what period do your records extend?	
2. What are the patient's chief complaint and other symptoms present upon consultation?	
3. When were you first consulted for this condition, and at that time, how long had he/she been experiencing these symptoms?	
4. On which date did the patient become aware of the condition?	
5. Has the patient previously suffered from the condition specified above or any possible related illness?	

6. Do you know of any other medical problem/s the patient had in the past? Please indicate in the table below

Date	Hospital/Clinic	Physician	Diagnosis	Treatment

7. Please give details of the patient's habits in relation to cigarette smoking or drinking.	

B. Medical Details

1. Please provide full and exact details of the diagnosis.	
2. What are the laboratory/ Diagnostic Procedures conducted?	
3. Had the insured undergone major organ transplantation? If so, please specify	

NAME OF THE PATIENT *:* _____

Last Name, First Name, Middle Name

4. What are the treatments / medications given?	
5. In your opinion, is the illness chronic or acute?	
6. What is the prognosis ?	

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

Date Attended	Name of the Physician	Address

8. Are there any predisposing or contributory factors in relation to the present illness? If yes, please specify.	

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.: