PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT – PRULADY Optional Benefits (Maternity Complications & Congenital Anomaly)

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 her health or her newborn. A claim has been submitted in connection with 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

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 symptoms/condition?	

B. Medical Details

B. 1 Maternity Complications (*for Congenital Anomaly Proceed to Questions on B.2*)

1. Please indicate the exact type of disease/illness or complications the patient is diagnosed of	
2. Please provide dates with full and complete details of the diagnosis	
3. Date the patient was informed of the diagnosis.	
4. Please provide dates & other details of investigations performed and attach copies of all relevant laboratory reports.	
5. Please provide details with dates of all operations performed, treatment and medication.	
6. How long has the insured been pregnant ?	
7. 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.	
8. Please provide complete name and address of all Consultants, Specialists or Hospitals to which your patient has been referred or attended for this condition.	
9. Is Patient HIV (Human Immuno-Deficiency Virus) positive? If so, please provide details including the date of diagnosis.	
10. Please provide details of patient's personal and family medical history.	

NAME OF THE PATIENT : _____

Last Name, First Name, Middle Name

B.2 Congenital Anomaly

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

1. Please describe fully the exact illness the above-named is diagnosed of.	
2. Please give exact date of the diagnosis of illness.	
3. How old was the child when the above illness was diagnosed?	

C. Other information

1. Is there any further information, which, in your opinion, will assist us in assessing the claim?	

DECLARATION
I HEREBY certify that the foregoing statements are correct

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: _____