PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - CRISIS COVER (Stroke)

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 stroke. 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.**

A. General

QUESTIONS	YES NO	PLEASE GIVE DETAILS TO "YES" ANSWERS
1. Are you the patients 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.	☐ ☐	
4. On which date did the patient become aware of the condition?		
5. Is there anything in the patient's family history which would have increased the risk of experiencing stroke? Please Describe.		
6. Please give details of the patient's habits in relation to cigarette smoking.		

B. Medical Details

1. Please provide dates with full and exact details of the diagnosis.		
2. Is there an evidence of a permanent neurological deficit ? Please describe.		
3. Is illness directly or indirectly contributed by a) Pregnancy or child birth b) Miscarriage or abortion c) Psychiatric disorders d) Drug or alcohol abuse	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

NAME OF THE PATIENT : _____

Last Name, First Name, Middle Name

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

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: _____