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PERMANENT AND TOTAL DISABILITY CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code _____ Policy No. _____

1 This printed form issued on receipt of notice of a claim, and is no way an admission of claim.
2 This form is to be completed by the Attending Doctor at claimant's expenses.
3 The Attending Physicain is required to provide full details of your patient's condition including the history and treatment given.

Definition

In order for a claim under this policy condition to be paid, the following definition must be satisfied :-
Disability such that there is neither at the time Disability commences nor at any time thereafter, any work occupation, or profession that the Life Assured can ever be capable of doing or following to earn or obtain any wages, compensation or profit, provided however, that such Disability must last for not less than six months in duration. The occurrence of any of the following shall also be considered as Total and Permanent Disability :-

i. total paralysis; or
ii. total and irrecoverable loss the sight of both eyes; or
iii. loss by severance of two limbs at or above wrist or ankle; or
iv. total paralysis of two limbs; or
v. total and irrecoverable loss of the light of one eye and loss by severance of one limb at or above wrist or ankle.

Personal Details

1 Patient's Name _____
2 I.C. No. _____
3 Age/Sex _____
4 Occupation _____
5 Main Duties _____

History

6 Are you the patient's usual Medical Attendant ? If so, since when?

_____

7 History and circumstances leading to disablity, please describe in detail, giving dates and mode of onset of the disability suffered by the patient, as related to you.

_____

_____

8 Date of beginning disability . ☐☐☐☐☐☐ (DD/MM/YY)

9 Date of first consultation for this disability. ☐☐☐☐☐☐ (DD/MM/YY)

10 Please give details of the clinical and physical findings noted by you when the patient was first seen.

_____

_____

11 Is this disability related to any other condition from which your patient has suffered in the past? If so, please give details.

_____

_____

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Claimant's Present Condition

12 Please provide a precise diagnosis to the patient present illness

13 Please describe your patient's current symptoms.

14 Is the patient suffering from any other condition and, if so, does it affect the condition described above?

15 How frequently does your patient consult you?

16 Since the diagnosis of his/her conditionn, has your patient :-

Recovered ☐ Improved ☐ Not change ☐ Deteriorated ☐

17 If your patient is fully recovered, please give date. ☐☐☐☐☐☐ (DD/MM/YY)

SMOKING

18 Do you have any details of your patient's smoking habit ? If so, please give details.

19 Have these smoking habits, to your knowledge, changed recently ?

TREATMENT

20 Please give full details of all medicines being prescribed for your patient, including dosage.

21 Please give details of any investigation test or procedures that have been undertaken in connnection with this condition, including the result.

22 Please give details of any surgical procedure performed in connection with his/her condition.

23 Please provide details of any other treatment being prescribed, including physiotheraphy.

24 Do you anticipate changing your patient's treatment in the immediate future or recommending that he/she undergoes further investigations or surgical procedures ?

25 Is he/she still receiving treatment from any other medical practitioner ? If so, please give details.

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DEGREE OF DISABILITY CURRECTLY BEING EXPERIENCED

26 Is your patient

i Ambulatory ☐
ii Confined to his/her home ☐
iii Confined to bed ☐
iv Subject to some other restriction in movement or lifestyle ? ☐
If so, please give details.

_____

27 How long has your patient been totally disabled from engaging in or attending to his/her usual business as a result of this disability ? Please give the date first absent from work.

_____

28 How much longer do you consider such total disablement will continue.

_____

29 Do you consider that your patient is capable of :-

i Following his/her normal occupation on a full time basis ? ☐ Yes ☐ No
ii Following his/her normal occupation on a part time basis ? ☐ Yes ☐ No
iii Following any other occupation ? ☐ Yes ☐ No

If yes, please give an indication as to the sort of work that he/she could undertake.

_____

30 Please give the date that you last examined the claimant. ☐☐☐☐☐☐ (DD/MM/YY)

31 Please grade your patient's function by the following scale :

1 Full function 2 Slight impairment 3 Substantial impairment 4 Nil function

	Left	Right
Knee	☐	☐
Legs	☐	☐
Hands	☐	☐
Arms	☐	☐
Shoulders	☐	☐
Climbing stairs	☐	
Climbing ladders	☐	
Walking	☐	
Standing	☐	
Kneeling	☐	
Bending	☐	
Lifting/Carring	☐	

32 Is there any other function impairment present ?

_____

_____

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33 If you have indicated that there is an impairment present, can you please advise whether that impairment is permanent or temporary. If the later, can you please give an indication as to how long the impairment may last.

34 Prognosis of claimant's condition

35 What aspect of your patient's disability will prevent him from undertaking any work in the future ?

36 When do you think your patient will be able to resume working, either to his present job or to alternative employment ?

Further Information

37 Please include any further informaton which you feel would be helpful in the assessment of your patient's claim

38 Do you have any hospital, consultants or diagnostic reports that would be of help to our Chief Medical Officer in the consideration of this claim ? If so, please furnish us the certify true copy of such reports.

Declaration

I hereby certify that I have personally examined the abovenamed patient and that the injuries/disability stated above represent my medical opinion of his/her current condition.

Signature of Physician
Date :

Physician's Name
Qualification

Clinic/Hospital Stamp Print