

CERTIFICATE OF ATTENDING PHYSICIAN

POLICYHOLDER _____ CLAIM NO. _____

MASTER POLICY NO. _____ POLICY/CERTIFICATE NO. _____

1. Name of Claimant _____ 2. Age _____
3. Residence Address _____
4. Occupation _____ 5. Height _____ 6. Weight _____
7. Are you his regular physician? _____ 8. How long have you known him? _____
9. When did you first attend to him for his present illness/injury? _____
10. Had you previously attended to him? YES () NO () If yes: _____

WHEN

FOR WHAT

11. Has he been treated by any other physician? YES () NO () If yes, please give their name(s) and address(es). _____

12. Has he received treatment in any hospital, sanitarium or other institution? YES () NO () If yes, please state name and address. _____

13. What and when were the earliest indications of illness noted by the insured? Give your basis. _____

14. In your opinion, when did the illness, which directly or indirectly caused the disability, commence? _____

15. Was he in good health up to the time of his present illness? YES () NO () If not, give details. _____

16. How would you classify his disability? () Partial Temporary () Partial Permanent () Total Temporary () Total Permanent

If partial, what in your opinion is the degree (percentage) of incapacity? _____

_____ %

17. If totally disabled, state when the total disability commenced and for how long. From _____ To _____

18. Please state your diagnosis of his case. _____

Interpretations, if any, of: Laboratory reports _____

X-ray _____

Electrocardiogram(s) _____

19. Was there any predisposing or contributing cause, remote or recent, for the present disability in the habits, family history, occupation or previous illness of the insured? YES () NO () If yes, describe fully _____