Attending Physician Statement - Individual Claim for Life Benefit

(To be filled by the attending physician)

FWD insurance

To: The Attending Physician
Dear Sir/Madam
Kindly your assistance to fill all the questions below completely and correctly to the extent of your knowledge of patient

Information of Insured

Patient's Name : ..... M/F Patient's Medical Record No. : .....

Date of Birth : ☐☐ - ☐☐ - ☐☐☐☐ Age : ..... y.o Patient's Address : .....

Type of Treatment ☐ Inpatient ☐ Pre-/Post-Hospitalization ☐ Accident ≥ / ≤ 48 hours before Hospitalization
☐ Critical Illness ☐ One Day Surgery ☐ Total Permanent Disability

Information of Treatment

Date of Treatment From ☐☐ - ☐☐ - ☐☐☐☐ to ☐☐ - ☐☐ - ☐☐☐☐

Anamnesis .....

Diagnosis .....

Cause of Treatment ☐ Accident ☐ Disease, please explain: .....

Please explain the indication for hospitalization : .....

Was the hospitalization requested by the patient ? ☐ Yes ☐ No

Could the treatment be performed without hospitalization? ☐ Yes ☐ No

When the diagnosis was first established ☐☐ - ☐☐ - ☐☐☐☐

When did the symptoms first occur to the Insured prior to the first consultation? ☐☐ - ☐☐ - ☐☐☐☐ or since: .....

The physician name who referred the patient : ..... Hospital : .....

Medical Examination Result : .....
(Laboratory, Radiology, MRI, CT scan, Angiography
Anatomy, phatology Anatomy, USG, etc.) .....

Has the surgical been performed : ☐ No ☐ Yes, please state the type of Surgery : .....

Purpose of Surgery : ☐ Curative ☐ Diagnostic

Was the diagnosis related to : ☐ Congenital ☐ Pregnancy, Delivery, or Abortion ☐ Psychiatric/Mental Disorder
☐ Cosmetic ☐ Medical Chekup ☐ Transmitted Sexual Disease
☐ HIV ☐ Alcohol/Drugs Abuse

Related to the Accident/Disability

Is there any part of the patient's body that suffer a disability?

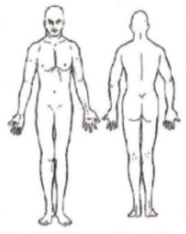
☐ No ☐ Yes, please explain the part fo body that has disability : .....

What is the type of disability

☐ Permanent ☐ Temporary

Could the patient perform his/her job or vocation after suffering form disability?

☐ No ☐ Yes, the patient might be able to start his/her job or vocation on/after how long : .....



Medical history

Does the Patient have a medical history that is related to the following diseases :
Hypertension, DM, Heart Disease, lungs, psychological, Congenital, Drugs Abuse, HIV, etc ☐ No ☐ Yes, please explain : .....

Diagnosis : ..... Since : ☐☐ - ☐☐ - ☐☐☐☐

The attending physician : ..... Hospital : .....

I hereby declare that I have read and answer all the questions above completely and correctly to the extent of my knowledge.

Doctor's Name : ..... Specialization : .....

Doctor's Address/Hospitali : .....

Home/Cell Phone No. : .....

Date ☐☐ - ☐☐ - ☐☐☐☐

(Doctor's Signature & Hospital Stamp)

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