Annexure – E (Form D)

Accidental Injury Hospital Cash Claim (Accident or Sickness)

Attending Physician's Statement

INSURED INFORMATION

Insured's Name________________________________ Date of Birth _____/_____/_______

Marital Status ____

Insured's Address____

____

Phone No: (H)_____________________Phone No. (W)______________________________

Name and address of employer

____

Please describe in detail the nature of the Insured's injuries,

____

____

Was the accident related to the Insured's occupation? ____________________ If so, how? ____

Was the Insured hospitalized? ______________ If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

____

____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ________If yes, please describe:

____

____

Were any surgical procedures performed? __________ If yes, please list all procedures, and dates performed:

____

____

What are the Insured's current subjective symptoms?

____

____

What are the objective findings? (Please include results of current x-rays, lab tests, etc.,)? ____

____

Dates of total disability:
From: _____/_____/_____
To: ____/____/____

Dates of partial disability:
From : ____/_____/______
To: _____/_____/_____

Date insured able to return to work: _____/_____/_____
Was the Insured seen by any other physician? ______ If yes, please list the names and addresses of all other physicians: ____

____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician:

____

Phone No: ____

Address:

____________________________-____

____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician)

____

DATE ____/____/____