GROUP PLUS
ATTENDING PHYSICIAN'S STATEMENT

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Required for Accidental Death & Disablement and Hospitalisation/Surgery. To be completed by the attending physician at the Insured Person's expense.

Name of Patient	
Passport/Identity No.	
What is the diagnosis and when was it diagnosed?	
When did the patient first consult you for the diagnosis?	
What were the signs or symptoms and complaints experienced by the patient prior to consulting you?	
Is the condition due to an injury/sickness/underlying medical condition? Please elaborate	
Has the patient consulted any doctors for the same diagnosis before?	☐ Yes ☐ No If yes, please indicate when, name and address of doctor treating the patient.
Is this a prearranged consultation or admission?	☐ Yes ☐ No If yes, please state the name and address of the referring doctor.
Is the condition / treatment related to:	Cosmetic surgery ☐ Yes ☐ No HIV ☐ Yes ☐ No Suicide, attempted suicide ☐ Yes ☐ No Self-infllicted injury ☐ Yes ☐ No General health screen ☐ Yes ☐ No If the answer is Yes to any of the above please elaborate
Is the patient still under your care for this condition?	
Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him from working	☐ Yes ☐ No If yes, please answer the following questions a) How long was, or will, the patient be continuously totally disabled (unable to work)? b) How long was, or will, the patient be partially disabled? Give details of any circumstances, such as intoxicated, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.

DECLARATION AND AUTHORISATION

I hereby certify that I have personally examined and treated the patient for the above *injuries/sickness and that the facts as given aboverepresent my opinion of *his/her condition.

Name of Physician		Tel no.	
Address			
Signature of Claimant/Guardian		Dated	D D M M Y Y Y Y
Company Stamp			

*delete as appropriate

AIG Bring on tomorrow

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