

Group Plus Attending Physician's Statement

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

1. Name of Patient: _____ Passport/Identity No.: _____

2. What is the diagnosis and when was it diagnosed? _____

3. When did the patient **first** consult you for the diagnosis? _____

4. What were the signs or symptoms and complaints experienced by the patient prior to consulting you? _____

5. Is the condition due to an injury/sickness/underlying medical condition? Please elaborate _____

6A. Has the patient consulted any doctors for the same diagnosis before? No Yes
If yes, please indicate **when**, name and address of doctor treating the patient.

6B. Is this a prearranged consultation or admission? No Yes
If yes, please state the name and address of the referring doctor.

7. Is the condition / treatment related to:

Cosmetic surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	HIV	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Suicide, attempted suicide	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Self-inflicted injury	<input type="checkbox"/> No	<input type="checkbox"/> Yes
General health screen	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

If the answer is Yes to any of the above please elaborate _____

8. Is the patient still under your care for this condition? _____

9. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him from working?
 No Yes (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? _____

C. 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 above represent my opinion of *his/her condition.

Name of physician: _____ Tel no.: _____

Address: _____

Signature: _____ Date: _____

Company Stamp.: _____ (*delete as appropriate)