## ACCIDENT CLAIM DOCTOR'S STATEMENT



												For Official Use																															
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Name of	f Lif	fe A	SSI	ıre	d:																																						_
																				N	IRI	IC/ I	Pa	ıssp	or	t No	o.:																
1. Dat Dat Dat	e o	f fir	st c	on	sult	ati		for		iis c	curi		t co				Day	·	Mon	th		Ye	ar																				
If th																	е	con	sul	tin	д у	ou,	pl	eas	e (	give	e n	am	e a	nd	ado	dre	ss c	of th	nat	do	ctoi	r.					_
2. (a)	D	eta	iled	d de	esci	rip	tior	า 01	f th	ne in	njur	ies																															_
(b)	(b) Please state the diagnosis:																		_																								
(c)	_ D	Detailed description of the accident.																																									
(d)	_ W	Were the injuries the result of the accident described above?  YES / NO*																																									
(e) (i) Were there any underlying illnesses/ conditions that attributed to the accident? If "YES", please provide full details of condition (including the type of condition, the date of onset, the extent infirmity) and describe how it attributed to the accident.										it of	f ph				NO enta																												
	(ii) What was the proximate cause of the injuries/ disabilities?																			_																							
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(f)	Was	s the Life Assured under the influence of alcohol/ drugs at the time of the accident?  YES / NO
	If "Y	ES", please state blood alcohol content/ drug type and quantity consumed:
(g)		the injuries result from a self-inflicted act?  ES", please give full description.
3. (a)	Wh	at is the Life Assured's occupation and nature of work?
(b)	Plea (i)	Period of *Total Disability: From:  *Total Disability refers to disability which prevents the Life Assured from performing each and every duty of his occupation
	(ii)	Were medical certificates issued for the above stated period?  If "NO", please provide reasons:
	(iii)	How and to what extent does the Life Assured's total disability prevent him/ her from performing all duties of his/ her occupation as stated above?
	(iv)	If the Life Assured is still totally disabled, how long is the total disability expected to last?
(c)	Plea (i)	Period of *Partial Disability: From:    Day   Month   Year   Day   Month   Year
		Date Signature of Doctor

	(ii)	Were medical certificates issued for the above stated period?
		If "NO", please provide reasons:
	(iii)	What are some of the duties and to what extent of the Life Assured's occupation that he/ she is unable to perform as a resul of his/ her partial disabilities?
	(iv)	If the Life Assured is still partially disabled, how long is the partial disability expected to last?
(d)	lf Li	ife Assured had been hospitalised or had undergone surgery, please state:
	(i)	Date admitted:    Day   Month   Year     Day   Month   Year     Day   Month   Year   Day   Month   Nonth   No
	(iii)	Name of Hospital:
	(iv)	Nature of Surgical Procedure:
	(v)	Date of Surgical Procedure:
	(vi)	Is further surgery likely to be required?    Day   Month   Year
		If "YES", please specify tentative date of surgery:
(a)		s the Life Assured suffering from any illness/ infirmity which was likely to protract the period of disability?  YES / NO
		ES", please give details:  Day Month Year  (1) B:
	(i)	Date of first diagnosis: (ii) Diagnosis:
	(iii)	Name and address of doctor who made diagnosis:
	(iv)	How it protracts the period of disability:
(b)	Wha	at would be the usual recovery time if the Life Assured did not have the illness/ infirmity?
		D-tr
		Date Signature of Doctor

4.

Did t	ne Life Assured suffer any fractures, dislocations or burns?			YES / NO							
	S", please tick where applicable.										
(i)	Fractures of hip or pelvis (excluding thigh or coccyx)										
	Multiple fractures, at least one compound and at least one	complete		All other compound fractures							
	☐ Mulitple fractures, at least one complete			Others fractures							
(ii)	Fractures of thigh or heel										
	☐ Multiple fractures, at least one compound and at least one	e complete		All other compound fractures							
	☐ Multiple fractures, at least one complete			Other fractures							
(iii)	Fractures of lower leg, skull, claride, ankle, elbows, upper or low fractures)	ver arm (includi	ng w	rists but excluding collen-type							
	$\ \square$ Multiple fractures, at least one compound and at least $\ $ one	complete		All other compound fractures							
	$\hfill\Box$ Depressed fracture of the skull needing $\hfill$ surgical intervention	on		Other fractures							
	☐ Multiple fractures, at least one complete										
(iv)	Fractures of collen-type fracture of the lower arm										
	☐ Compound fracture	Other	fractu	ures							
(v)	Fractures of shoulder blade, knee cap, sternum, hand (excluding	ng fingers and v	vrists	s), foot (excluding toes or heel)							
	☐ All compound fractures	Other	fractu	ures							
(vi)	Fractures of spinal column (vertebrae but excluding coccyx)										
	☐ All compressions fractures	☐ All spir	ous,	transvere process of pedicle fractures							
	Fracture leading to permanent neurological damage	Other	/ertel	orae fractures							
(vii)	Fractures of lower jaw										
	☐ Multiple fractures, at least one compound and at least one comp	plete 🗆 All othe	er co	mpound fractures							
	Multiple fractures, at least one complete	Other f	ractu	ires							
(viii)	(viii) Fractures of rib or ribs, cheek bone, coccyx, upper jaw, nose, toe or toes, finger or fingers										
	☐ Multiple fractures, at least one compound and at least one comp	olete  All othe	er cor	mpound fractures							
	Multiple fractures, at least one complete	Other f	ractu	res							
	Date			Signature of Doctor							

5.

	(ix) Burns: 2nd or 3r	d degree burns on										
	at least 27%	of body surface	at least 18%	of body surface								
	at least 9% o	f body surface	at least 4.59	at least 4.5% of body surface								
	(x) Dislocations req	uiring surgery under anaesthesia										
	☐ Spine or bac	k, diagnosed by X-ray (excluding slippe	ed disc)									
	☐ Knee		☐ Wrist or elb	OW								
	Ankle, should	der blade or collarbone	☐ Fingers, too	es or jaw								
	☐ Internal injur	ies resulting in open abdominal or thora	acic surgery (excluding hernia)									
6.	Has the Life Assured b	een admitted to any hospital before, ei	ther for the same or different caus	se? YES / NO*								
	Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)								
7.	Please provide us with	any other additional information that w	rill enable the Company to assess	this claim.								
	Date		Si	gnature & Official Stamp of Doctor								