AIG

Claim Form

Attending Physicians Statement

Reference Number | Policy Number | Sex ☐ M ☐ F | Age

The insured is responsible for completion of this form without expense to the company

Patient's name and address

What is disabling patient?

Please give a complete diagnosis of this condition

History

1. When did patient first receive medical treatment?
2. (a) Was there a previous history of this or a similar condition? ☐ Yes ☐ No
   (b) If yes, please state condition and advise when previous treatment was given
3. (a) How long have you known the patient?
   (b) Are you the regular general practitioner? ☐ Yes ☐ No
   If not, please advise who is

If Injury

1. When did patient suffer the injury?
2. What were the circumstances surrounding the injury?

If Sickness

1. When was sickness first contracted?
2. When did symptoms become evident?

Degree Of Disability

1. Patient's Occupation?
2. When was patient obliged to cease work?
3. If Patient is still disabled, when approximately will the patient be able to resume
   (a) Some Duties?
   (b) Full duties?

OR

4. If patient has recovered, when was patient able to resume
   (a) Some Duties?
   (b) Full duties?

Treatment Of Present Condition

1. When were you consulted? (a) Initially (b) Most Recently

2. How often has patient consulted you?

3. Was patient confined to hospital? ☐ Yes ☐ No

   If Yes, please advise

   1. Name and address of hospital

   2. Period of Confinement From / / To / /

4. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No

   If Yes, give details

5. What are the current subjective symptoms?

6. Please give results of any objective findings

   1. X-Rays

   2. Other Tests - Please advise tests done and findings 1

      2

7. What surgical procedures have been performed? 1

      2

8. What surgical procedures are contemplated? 1

      2

9. What other treatment has patient undergone?

10. What other treatment is required?

Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No

If Yes, please advise nature of underlying conditions and how they affect disability and recovery

Has patient any other physical or mental impairment? ☐ Yes ☐ No

If Yes, please describe

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date / /

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability at present? ☐ Yes ☐ No

If Yes, please explain giving estimated percentage loss of function

Signed

Date / /

Degree

Name (Please print)

Street Address

City or Town

State

Phone No [ ]

PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD

AIG Bring on tomorrow

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