

## DOCTOR'S STATEMENT – INDIVIDUAL CLAIM FOR LIVING BENEFIT

(To be completed by the attending physician)

To the Attending Physician,

We kindly request your assistance in completing this Doctor's Certificate with the utmost accuracy, based solely on the medical data available and your professional knowledge.

### INSURED INFORMATIONS

Patient's Name : \_\_\_\_\_ M/F Patient's Medical Record No. : \_\_\_\_\_  
 Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) / Age \_\_\_\_ y.o. Patient's Address : \_\_\_\_\_  
 Type of Treatment : ☐ Inpatient ☐ Pre/Post Inpatient ☐ Accident ≥/ ≤ 48 hours prior to the hospitalization  
☐ Total Permanent Disability ☐ One Day Surgery ☐ Critical Illness

### TREATMENT INFORMATION

Date of Treatment : \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
 Patient's Complaints / Symptoms : \_\_\_\_\_  
 Medical History / Anamnesis : \_\_\_\_\_  
 Medical Diagnosis : \_\_\_\_\_  
 Reason for Medical Care : ☐ Accident ☐ Disease, Explanation \_\_\_\_\_  
 Date of First Confirmed Diagnosis : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
 Onset of Symptoms Prior to First Consultation : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) / For how long \_\_\_\_\_  
 Attending Physician : \_\_\_\_\_ Hospital : \_\_\_\_\_

Result of Supporting Examinationss  
 (Laboratory, Radiology, MRI, CT Scan, Angiography, Pathology Anatomy, USG)

Surgical Procedure Type (if applicable) : ☐ No ☐ Yes, Please specify the surgical procedures performed \_\_\_\_\_  
 Objective of the Surgical Procedure : ☐ Curative ☐ Diagnostic  
 Does the aforementioned diagnosis pertain to ☐ Congenital Disorders ☐ Pregnancy, Delivery, Miscarriage ☐ Psychiatric  
☐ Cosmetic ☐ Routine Health Examinations ☐ Sexually Transmitted Diseases  
☐ HIV ☐ Alcohol and Substance Abuse / Drug Dependence

### IF RELATED TO ACCIDENT OR DISABILITY

Are there any anatomical abnormalities or disabilities observed in the patient?

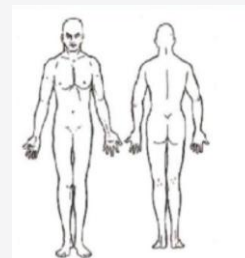
☐ No ☐ Yes, Please indicate the anatomical region where the deformity is present. \_\_\_\_\_

What is the nature of the disability?

☐ Permanent ☐ Temporary

Is the patient capable of resuming their occupational responsibilities following the onset of this disability?

☐ No ☐ Yes, the insured is expected to be able to resume work. Please specify the estimated timeframe. \_\_\_\_\_



### HISTORY OF PRE-EXISTING MEDICAL CONDITIONS

Does the patient have any current or previous medical conditions such as hypertension, diabetes mellitus, heart disease, pulmonary disorders, psychiatric conditions, congenital diseases, substance abuse, HIV, or others?

☐ No ☐ Yes, please explain \_\_\_\_\_

Diagnostic : \_\_\_\_\_ Date of Onset : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)

Attending Physician : \_\_\_\_\_

I hereby certify that I have read and provided complete and accurate responses

:

:

Phone or Mobile Number :

Name and Address of the Attending Physician

(Physician's Signature and Hospital Stamp)