Total Disability Benefits

Attending Physician's Statement

Gulf Operations
P.O. Box 371916, Dubai, UAE - Tel. 04 415 4555, Fax 04 415 4445

▶ Please provide all relevant information completely and legibly.

By giving full and complete answers, the Attending Physician will assist the Company in passing promptly on the claim. This statement is to be furnished without expense to the Company.

1. **Full name of the Insured**

2. **Where is the Insured now located?** (If an inmate of a hospital or other institution give name and address)

3. **How long have you been the Insured's medical advisor?**

4. **When did the Insured's health first become affected?** D D M M Y Y Y Y

5. **Give symptoms, diagnosis and prognosis of disability**

6. **(a) Is the Insured wholly disabled and prevented from engaging in any business or occupation whatsoever?**

   (b) If he/she is, from what date, to your knowledge, has he/she been so prevented? D D M M Y Y Y Y

7. **(a) Date of your first visit or prescription in present affliction** D D M M Y Y Y Y

   (b) Date of your last visit or prescription in present affliction D D M M Y Y Y Y

8. **Is the Insured now confined to his bed or house? State which** **and from what date?** D D M M Y Y Y Y

9. **When, in your opinion, may the Insured be expected to do any kind of work?**

10. **Have you or any other physicians or practitioners attended or treated the Insured for any cause whatsoever prior to present affliction?**

a. Nature of diseases or injuries	b. Dates of Attendance		c. Names of Physicians or Practitioners	d. Address
	From	to		

11. **Has the Insured ever received treatment from specific disease?** If so, Please provide particulars

12. **Has any member on the Insured's family or any person in his/her immediate household ever been afflicted similarly? If so, who?**

Additional Remarks

If heart is involved, what laboratory tests have been made?

Pulse Irregular Blood Pressure

S D

Full name of the Physician

Signature of Physician X Residence Tel. No. Include Country & Area Code

Signed at City Country D D Day M M Month 20 Y Y Year