CERTIFICATE OF ATTENDING PHYSICIAN
DISABILITY CLAIM FORM NO. 2

NOTE: Please use reverse side for answers requiring additional information not called for in this questionnaire. Identify your answers with corresponding item numbers.

POLICYHOLDER:_____MASTER POLICY NO. _____

1. Full Name of Insured:_____Certificate No. _____
2. Present Address :_____3. Age _____
4. Occupation : _____ 5. Height _____ 6. Weight _____

7. Are you his/her regular physician?_____8. How long have you known him? _____
9. Have you previously attended him? If so,

W H E N	FOR WHAT
_____	_____
_____	_____
_____	_____

10. Has he/she been treated by any other physician? If so, give their names and addresses.

NAME OF PHYSICIAN	ADDRESS
_____	_____
_____	_____
_____	_____

11. Has he/she received treatment, in any hospital, sanitarium or other institution? If so, state where.
_____
12. What and when were the earliest indications of illness noted by him/her. Give your basis.
_____
13. When, in your opinion, did the illness which directly or indirectly caused the disability commence?
_____
14. Was he/she in good health up to the time of his/her present illness? If not, give details. _____
_____
15. How would you classify his/her disability? ( ) Partial-Temporary ( ) Partial-Permanent
( ) Total-Permanent ( ) Total Temporary
If partial, what in your opinion, is the degree of incapacity? _____
16. If totally disabled, since when? _____
17. Is he/she not totally disabled? _____
18. What is your diagnosis? _____
Interpretations, if any, of Laboratory reports : _____
X-ray:_____ Electrocardiograms: _____
19. Was there any predisposing or contributing cause, remote or recent, fo r the present disability in the family history, occupation or previous illness of the Insured? If so, describe, fully. _____

* * * see back page * * *

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20. Is any surgical operation contemplated or has one been performed? If so,
    What?_____
    When?_____Where? _____
    By whom _____
21. What is the prognosis? _____
22. When in your opinion, can he/she resume his/her usual occupation or employment?
    _____

I,_ hereby certify that the answers given above are (Printed Name of Physician)
full, complete and true. I am a graduate of_____in the
(Medical College)
year_____.

Dated and signed at_____on_____,_____.

_____
FULL ADDRESS OF PHYSICIAN

_____
PHYSICIAN'S SIGNATURE
PTR No. _____
Date Issued _____
Place of Issue _____

_____
SIGNATURE OF INSURED
(Must be signed in the presence of the
Attending Physician)