



PHYSICIAN'S STATEMENT

Claim under the Disability Waiver Certificates

CLAIMANT:

1. Name	
2. Address	
3. Occupation	4. Apparent Age
5. Height	6. Weight

MEDICAL HISTORY:

7. Are you his regular physician?
8. How long have you known him?
9. When did you first visit him for his present illness?
10. Have you previously attended him? If so WHEN? _____ FOR WHAT? _____ _____
11. Has he been treated by any other physician? If so, give their names. _____ _____
12. Has he received treatment in any hospital, sanitarium or other institution? If so, state where. _____ _____ _____
13. What and when were the earliest indications of illness noted by the insured? Give your basis.
14. When in your opinion did the illness which directly or indirectly caused the disability commence?
15. Was he in good health up to the time of his present illness? If not, give details.

DISABILITY:

16. How would you classify his disability? Total-Permanent Total Temporary Partial-Permanent Partial-Temporary If partial, what in your opinion, is the degree of incapacity? %
17. If totally disabled, since when?
18. Is he now totally disabled?

DIAGNOSIS:

19. What is your diagnosis? Interpretations, if any, of Laboratory reports: X-ray: Electrocardiograms:
20. Was there any predisposing or contributing cause, remote or recent, for the present disability in the family history, occupation or previous illness of the Insured? If so, describe fully.
21. Is any surgical operation contemplated or has one been performed? If so, What? _____ When? _____ Where? _____ By whom? _____

PROGNOSIS:

22. What is the prognosis?

I, _____ hereby certify
 (Physician's name in full)
 that the answers given above are full, complete and true, I
 am a graduate of _____ in the year _____.
 (Medical College)

 Physician's Signature

 Address in full

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

 Signature of the insured Date
 (must be signed in the presence of the Attending Physician)