LIFE GOALS. **DONE.**

BAJAJ | Allianz

Attending Physicians Statement- Disability Benefit Claims

(Applicable for PAB, WOP and Payor Rider Disability Claims)

(A qualified and registered medical practitioner should complete this form. Policy Holder, Life Insured who are also medical practitioners or their Spouse, or Lineal Relative of Policy Holder/Life assured cannot fill it).

I. General Information

1 a) Name of the Patient _____ b) Age _____

2.Are you the patient's usual doctor? If "yes", please give details. How long have you known the Patient?
Date of consultation _____ Diagnosis _____ Treatment given _____

3.Was the patient referred to you by another doctor or hospital? If "Yes", please give details:

Name of doctor/ hospital _____ Address of doctor/hospital _____

II. Information about the Disability

1. Date of Accident/Diagnosis/Disability, as the case may be _____
2. Details of Diagnosis _____

_____

3. Nature of Disability-(Tick any one) Permanent ☐ Temporary ☐
4. Extent of Disability-(Tick any one) Total ☐ Partial ☐
5. Is the Patient capable of performing the following activities of daily living

Dressing ☐ Using the Toilet ☐ Walking ☐ Feeding Him/Herself ☐ Using Telephone ☐ Bathing ☐ Taking Medication ☐

6. Is the Patient capable of engaging in any gainful activity or carrying out any work, occupation, or profession to earn or obtain any wages, compensation, remuneration or profit
7. Any Other Past Medical History _____
8. What is the prognosis _____

III. Other Information

1. Name and address of hospital where patient was admitted: _____

_____

2. Date of Admission _____ 3. Date of Discharge _____
3. Any other information, which in your opinion will assist us in a assessing this claim? If "Yes", please give details below.

_____

I _____ Medical Attendant of the Life Assured _____

_____ do hereby solemnly declare that the above statements are true and correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ 20 _____

Stamp of Medical Attendant

Signature of Medical Attendant _____
Name of Medical Attendant _____
Qualifications _____
Phone Number _____
Mobile No. _____ Email ID _____