SECTION C. ATTENDING PHYSICIANS' STATEMENT

(Please comment in detail for each category listed below, especially in regard to the severity of the illness. The information you provide is essential for your patient to obtain Sickness & Accident benefits.)

Patient's Name _____ Age _____

Symptoms _____

Test Results _____

Diagnosis _____

Treatment _____

Frequency of Treatments _____

Prognosis _____

If condition is related to pregnancy, give estimated date of confinement (EDC) _____

What other medical conditions is the patient under your care for? _____

Date(s) of treatment: Outpatient _____

Inpatient _____

Surgical Procedures, if any _____

Date(s) Performed _____ Where _____

How does this condition affect patient's work capacity? _____

Are accommodation(s) necessary for full or modified duty? _____

Is patient totally disabled from his/her usual job? Yes _____ No _____ From any job? Yes _____ No _____

Anticipated length of total disability _____ Partial disability _____

Next scheduled appointment _____

Comments _____

_____

Please note that medical records may be requested to support the claim of total disability for Sickness and Accident benefits as required by our benefit plan.

Physician's Name _____

Specialty _____

Address _____

_____

Phone No. (_____) _____

Signature _____

Date _____