ATTENDING PHYSICIAN FORM

SECTION A : PERSONAL / CORPORATE DETAILS

Name of Insured in full _____

Postal Address: _____ Postal Code: _____ Town: _____

Physical Address: Bldg: _____ Floor: _____ Street: _____

Office Tel: _____ Fax No.: _____ Mobile Phone: _____

E-Mail Address: _____

Policy Number: _____

SECTION B : TECHNICAL DETAILS

HISTORY

(a) When did present injury or illness begin? _____

(b) If accidental injury, give details of accident? Any evidence of visible contusion or wound? _____

_____

(c) Was patient at time of this accident or during this disability affected with any previous injury or any other disease? YES ☐ NO ☐

If yes, please give particulars _____

(d) To your knowledge did he have any infirmity or physical impairment prior to this accident, or disability? If so, did it contribute to cause the accident or prolong the disability?

YES ☐ NO ☐

(e) Was the operation performed? YES ☐ NO ☐

If yes, please describe _____

(f) For what periods was patient

Hospital confined	From _____	To _____
House confined	From _____	To _____
Bed confined	From _____	To _____
Ambulatory	From _____	To _____

DIAGNOSIS

If injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture of long bones occurred, state whether through head or shaft.

_____

_____

_____

_____

TREATMENT

Date of first visit _____

Date of last visit _____

Total Number of visits _____

DESCRIBE PRESENT CONDITION

Indicatee if recovered, improved or retrogressed. Also indicate percentage of permanent disability if applicable

_____

_____

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SECTION B : TECHNICAL DETAILS (continued)

DEGREE OF LENGTH OF DISABILITY

(a) From what dates has patient been unable to perform any part of his occupation? From_____ To_____

(b) From what dates has patient been unable to perform some part, but not all, of his occupation? From_____ To_____

(c) If not working, when do you think he will be able to work?

Approx. Date_____

Indefinite_____

Never _____

SECTION C : DECLARATION

i. **Privacy Statement**

By completing this form, you have provided AIG with your personal information. AIG is committed to protecting the integrity, confidentiality, access and use of personal information that we collect from you in the course of our business. "Personal Information" is information that identifies and relates to you or other individuals (such as your dependants). You have the right to access and correct personal data that may be incorrect or incomplete. I hereby authorize AIG to use my personal information for lawful business purposes. For more information on how we handle personal information kindly obtain a copy of our privacy policy from our office.

ii. **Declaration**

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for AIG to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

I/We hereby acknowledge the contents of the statements i and ii above.

Doctor's Name:_____

Signature: _____ Date: _____

Company Stamp