

CLAIM FORM

Physician's Report In Case of Disability Assessment



A member of the Pacific Cross Group of Companies

Please complete this form by a licensed doctor. The insured is responsible for the incurred fees.

1	Insured's First names - Surname : Age : Height : Weight :				
1.1	For Accident	Date of accident :/...../..... Time : hrs.			
1.2	For Illness	The duration of the illness :			
2	Specify the cause and severity of the disability :				
3	Please specify the results of the neurological, laboratory and X-ray examinations or other special tests :				
4	Please specify the treatment the insured has received since the disability began. :				
5	Diagnosis :				
6	Complications :				
7	You have treated the patient from : to At : Type of treatment :				
8	Physical examination				
8.1	Strength of Muscle	Arm	Right Grade: 0 I II III IV V	Leg	Right Grade: 0 I II III IV V
			Left Grade: 0 I II III IV V		Left Grade: 0 I II III IV V
8.2	Consciousness	<input type="radio"/> Conscious <input type="radio"/> Confused <input type="radio"/> Drowsy <input type="radio"/> Unconscious			
8.3	Hearing ability	<input type="radio"/> Normal <input type="radio"/> Difficult <input type="radio"/> No			
8.4	Speech ability	<input type="radio"/> Normal <input type="radio"/> Difficult <input type="radio"/> No			
8.5	Daily activity ability	<input type="radio"/> By him / herself <input type="radio"/> By him / herself with assistance of other <input type="radio"/> No			
8.6	Walking ability / mobility	<input type="radio"/> By him / herself <input type="radio"/> By him / herself with supporting equipment <input type="radio"/> No			
8.7	Work performance ability	<input type="radio"/> Yes <input type="radio"/> Yes, only in a suitable environment <input type="radio"/> No			
8.8	Type of disability	<input type="radio"/> Temporary Total Disability <input type="radio"/> Permanent Partial Disability <input type="radio"/> Permanent Total Disability			
8.9	Prognosis	<input type="radio"/> Improve <input type="radio"/> Unchanged <input type="radio"/> Worse			
8.10	Additional opinion			

Physician's Name :		Signature :			
License No. (Completion is Compulsory)	Degree	Certificate / Approved Card/ Branch
Hospital's Name	Telephone No.	Date of examination

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