PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

# Attending Physician's Statement - Disability Claim

Note: **PLEASE SIGN ON ALL PAGES AT BOTTOM**.

**DOCTOR'S DETAILS:**

Name of the Attending Physician: _____

Name of the Clinic / Hospital: _____

Address: _____

Contact No.: _____ E-mail address: _____

**CLAIMANT/PATIENT'S DETAILS:**

Name of the Claimant: _____

Address: _____

Age & Sex: _____ Hospital/Indoor Patient Number: _____

**SPECIFY WHICH DISABILITY IS APPLICABLE:**

- ☐ Loss of sight of one Eye
- ☐ Loss on use of one Limb
- ☐ Loss of sight of both the eyes
- ☐ Loss of Hearing
- ☐ Loss of use of two limbs
- ☐ Loss of one limb & loss of sight of one eye
- ☐ Loss of speech and hearing
- ☐ Loss of Speech

**HISTORY**

Date of first Consultation: _____

Details of the Doctor who treated first: _____

_____

Date of appearance of first symptoms: _____

Has the patient ever had the same or similar condition in past: ☐ Yes ☐ No

(If "yes," state when and provide details. Kindly attach another sheet if required): _____

_____

**PRESENT CONDITION:**

Subjective symptoms: _____

Objective findings (include results of current X-rays, ECGs or any other special tests):_____

_____

**DIAGNOSIS:**

Please provide details:_____

_____

_____

**TREATMENT:**

Date of first visit: _____

OP Number/Hospital No/Indoor Patient No.:_____

Date of last visit: _____ Frequency of visits (Weekly/Monthly/Other): _____

Date of Last examination: _____

Is this Disability permanent: _____

Is this Disability Reversible: _____

What was the cause of disability: _____

Is this disability result of Accident: _____

**PROGRESS:**

❒ Recovered ❒ Improved ❒ Unimproved ❒ Retrogressed

**MENTAL CONDITION:**

Is the patient competent to endorse checks and direct the use of proceeds there of? ❒ Yes ❒ No

**DECLARATION:**

These statements are true and complete to the best of my knowledge and belief.

Name & Signature of the Physician: _____ Date: _____

Qualifications: _____

Reg. No.: _____ (Seal)