CHUBB®

Disability Claim
Attending Physician's Statement
(to be completed by Registered Medical Practitioner at the claimant's own expense)

Policy no. | | | | | | | | | | |

A. General Information

Patient's name	HKID Card/passport no.	Date of birth DD MM YYYY / /	Sex	Age

Are you the patient's usual doctor? ☐ Yes ☐ No Since when (/ /) DD MM YYYY

B. History & Diagnosis

1. The date when symptoms first appeared or accident happened
(/ /) DD MM YYYY

2. Symptoms and complaints presented by the patient

3. If the condition was due to accident, please provide the cause of this accident

4. The date of first consultation
(/ /) DD MM YYYY

5. Clinical and physical findings

6. The date when the diagnosis was first given
(/ /) DD MM YYYY

7. If surgery perfomed, please describe fully the date and nature of surgery
(/ /) DD MM YYYY

8. The final diagnosis of the condition and its complications

9. The date the patient was first absent from work due to this condition

10. Has the patient ever had same or similar condition? If so, please state when and give details.
☐ Yes ☐ No (/ /) DD MM YYYY Diagnosis: ____________________

11. Details of consultations and treatment rendered by you / hospital

Date/period (DD MM YYYY)	Treatment details	Investigation/procedure

12. Name and address of other doctors / hospitals attended for treatment of this condition

Date of treatment (DD MM YYYY)	Physician/hospital attended	Address

C. Health Conditions

1. Progress of recovery
   ☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed
   Remarks:

2. Current state of mobility, give name of hospital and the period of confinement, if any.
   ☐ Ambulatory ☐ Home confined ☐ Bed confined ☐ Hospital confined
   Remarks:

3. Please describe the current physical improvement of the patient.

4. Can the patient perform Daily Living Activities without the use of mechanical equipment, special device or other aids and adaptations during the disability period?

Transfer (to get in bed and out of bed or chair):	☐ Yes	☐ No
Mobility:	☐ Yes	☐ No
Dressing:	☐ Yes	☐ No
Bathing & Washing:	☐ Yes	☐ No
Eating	☐ Yes	☐ No
Toileting:	☐ Yes	☐ No

   Remarks:

5. Did the patient sustain the following disablement:

a. Total and irremediable blindness (total loss of sight)	☐ Yes	☐ No	Which eye(s) ______
Severance of limb(s)	☐ Yes	☐ No	Please specify which limb(s) and the joint involved ______
Physical and/or total functional disablement of limb(s)	☐ Yes	☐ No	Please specify which limb(s) and the joint involved ______
Permanent and total loss of hearing	☐ Yes	☐ No	Which ear(s) ______

   b. Has the patient suffered the above disablement continuously and without interruption for 180 days as a result of the condition as stated in Part B? ☐ Yes ☐ No

6. With the health condition of the patient in mind, what would you rate the working capacity of the patient during the disability period, please tick the appropriate.
   ☐ No limitation of functional capacity, capable of heavy work without restriction.
   ☐ Capable of medium manual activity.
   ☐ Slight limitation of functional capacity, capable of light work.
   ☐ Moderate limitation of functional capacity, capable of clerical / administrative activity.
   ☐ Severe limitation of functional capacity, incapable of minimum activity.
   Remarks:

7. Please describe the mental impairment of the patient during the disability period. (if normal, please go the Part D)

8. With the mental status of the patient as described above, what would you rate the ability for interpersonal relations and communication of the patient, please tick the appropriate.
   ☐ Able to engage in all interpersonal relations and communication (without limitations)
   ☐ Able to engage in most interpersonal relations and communication (slight limitations)
   ☐ Able to engage in only limited interpersonal relations and communication (moderate limitations)
   ☐ Unable to engage in interpersonal relations and communication (maked limitations)
   ☐ Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
   Remarks:

D. Prognosis & Rehabilitation

1. Is the patient TOTALLY DISABLED for

His / her own job	☐ Yes	☐ No	From (/ /) DD MM YYYY	To (/ /) DD MM YYYY
Any other jobs	☐ Yes	☐ No	From (/ /) DD MM YYYY	To (/ /) DD MM YYYY

2. If the patient is unable to return to his / her own occupation, what other type of occupation can he / she perform?

3. If the patient is still disabled, please give approximate date the insured should be able to return to work?

(/ /) DD MM YYYY

4. How long was or will the patient be partially disabled?

From (/ /) DD MM YYYY To (/ /) DD MM YYYY

5. What duties of the patient's job is he / she incapable of performing?

6. Do you expect a fundamental or marked change of this present condition in the future. ☐ Yes ☐ No (if 'No", go to question 7)
If yes, how long do you expect the patient will take to perform duties.

In terms of own job:
☐ Within 1 Mth
☐ 1-3 Mths
☐ 3-6 Mths
☐ 6-12 Mths
☐ >12 Mths
☐ Never
Remarks:

In terms of any other job:
☐ Within 1 Mth
☐ 1-3 Mths
☐ 3-6 Mths
☐ 6-12 Mths
☐ >12 Mths
☐ Never
Remarks:

7. If answer of question 6 is 'No', please explain

8. Please state any further treatment/rehabilitation

E. Miscellaneous

1. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this condition.

2. Is there any further information which in your opinion will assist us in assessing this claim?

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.

Name of physician (with stamp)	Qualification	Signature	Date

Address: ______________________

Tel no.: ______________________

Chubb. Insured.[SM]