pnb MetLife
Milkar life aage badhaein

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)