CIC AFRICA LIFE ASSURANCE LTD.

PHYSICIAN'S STATEMENT OF DISABILITY

Policy No: _____

CIC GROUP

Name of Patient: _____

Postal Address: _____ Code: _____ Town: _____

Employer: _____

1. During what time have you been treating the patient? From: _____ To: _____

Number of occasions: _____

2. Diagnosis: _____

3. What are the symptoms? _____

4. When did the first symptoms appear or accident happen? _____

5. Has the patient indicated the cause of the complaint? Yes ☐ No ☐
If yes, give details

_____

_____

_____

_____

6. Has the patient previously suffered from the same or similar illness or injury? Yes ☐ No ☐

7. Objective findings (Please give date and report of Surgery, X-ray, EKGs or other special tests

_____

_____

_____

8. Any special circumstances which may have a bearing on the occurrence or progress of the patient's condition (intoxication, other illnesses etc.)

_____

_____

_____

9. Is the patient (Tick one)
Ambulatory? ☐ House confined? ☐
Bed confined? ☐ Hospital confined? ☐

10. Progress? (Tick one)
Recovered? ☐ Improved? ☐
Unimproved? ☐ Retrogressed? ☐

11. Prognosis: _____

12. Could rehabilitation and job training result in gainful employment?

DEGREE OF DISABILITY

13. If disability is temporary, when can the patient be expected to return to work of any type?

14. If disability is total and permanent, which means the patient is permanently unable to engage in any occupation or perform any type of work, give date the disability began

15. Remarks

Name of Physician: Signature: Date:

Postal Address: Code: Town: