



**PERSONAL ACCIDENT
Attending Physician's Statement**

To be completed by the Attending Physician. The Insured is responsible for the completion of this form without expense to Sagicor Life Jamaica.

History

Name of Patient _____ Date of Birth _____ Policy Number _____

When did symptoms first appear or accident happen? Date _____ Time _____

Where and how did accident happen? _____

Date patient ceased work because of disability _____

Has patient ever had same or similar condition? _____

To your knowledge, did the Insured have any infirmity or physical impairment prior to this accident or disability? If so did it contribute to cause the accident or prolong the disability? _____

Was the patient at time of accident or during this disability, affected with any previous injury or disease? If so, explain. _____

Present Condition and Diagnosis

Describe present condition (indicate if recovered, improved, unimproved or retrogressed).

Diagnosis _____

Treatment _____

Was operation performed? _____

Hospital Confined From _____ To _____ Bed Confined From _____ To _____

House Confined From _____ To _____ Ambulatory From _____ To _____

Degree & Length of Disability

From what date has patient been unable to perform any part of his occupation? _____ Number of days disabled _____

From what date had patient been able to perform some part, but not all, of his occupation? _____ Number of days _____

If not working, when do you think he will be able to work (In any occupation which he is reasonably qualified)? Approx Date _____ Indefinitely _____ Never _____

Charges

Office Consultations			
Date of first visit		Date of last visit	
Number of visits		Charge per visit	
		Total Charges	

Treatments	
Total charge for treatment in office	
Other Charges	
Total Charges	

Hospital			
Number of days confined in hospital		Charge per day	
In-hospital surgical expenses		Total Charges	

I hereby certify that my answers to the foregoing questions are correct and true to the best of my knowledge and belief

Physicians Signature

Dated

Stamp

Address

Remarks _____

Declaration