

**Attending Physician's Statement  
 Critical Illness – Stroke**
**PART II - To be completed by doctor at Insured's/Claimant's expense**

Policy No.				
Name of Insured	ID Card No.	Age	Date of Birth	Sex

**GENERAL INFORMATION**

1. Are you the Insured's usual medical physician?  If "yes", over what period do your records extend?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. When were you first consulted for this illness?  What were the symptoms and at that time how long had they been present?	_____ DD / MM / YY	
3. Are you aware of whether the Insured had previously suffered from this illness or any related conditions?  If "yes", please provide names, addresses and dates of doctors or hospitals which the Insured has been referred and/or admitted to and the resulting diagnosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name of physician/facility	Address	Date of consultation / confinement period
_____	_____	_____
_____	_____	_____
_____	_____	_____
Diagnosis:		
4. On which date was the diagnosis made?  On which date was the insured first made aware of it?	_____ DD / MM / YY	
	_____ DD / MM / YY	
5. Is there anything in the insured's family history which would have increased the risk of this illness?  If "yes", please give details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Please provide names, addresses and dates of doctors and hospitals which the Insured has been referred and/or admitted to for diagnosis/treatment of this current episode / illness.		
Name of physician/facility	Address	Date of consultation / confinement period
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

