ONE

PRIME ASSET COVER

## MEDICAL CERTIFICATE (To be completed by the Doctor consulted)

| | | | |
|---|---|---|---|
| Policy Number | | Type | |
| Broker / Agent | | | |

**The Patient must obtain, at his own expense, the following certificate from a duly qualified and registered Medical Practitioner**

When the patient is fully recovered a Doctor's certificate to that effect should be forwarded to the insurers showing the periods of partial and total incapacity.

| | | | | | |
|---|---|---|---|---|---|
| Patient Name | | Height | | Weight | |

1. When did you first attend to the Patient in consequence of the Accident / Illness sustained?

2. Are you still in attendance? Yes ☐ No ☐

3. Are you the usual Medical attendant of the Patient Yes ☐ No ☐

If YES, for how long have you known him/her?

4. What was the cause of the Accident / Illness so far as known?

5. What injuries were sustained?

5a. Region insured (if hand or arm, leg or foot, please state if it was the left side or the right side

5b. Are the symptoms from which he/she suffers due to:

(i) the Accident / Illness alone, or Yes ☐ No ☐

(ii) are they traceable to any other cause? Yes ☐ No ☐



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6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the Accident?

7. Is the Patient now, or was he / she at the time of the Accident / Illness subject to or suffering from any illness or disease irrespective of the Accident / Illness for which the benefit is claimed? If so, state the nature of same, and to what extent the Patient may be affected thereby.

8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his / her previous medical history which might have contributed directly or indirectly, to the occurrence of the Accident / Illness, or which may be likely to retard in any way recovery from it?

9a. Is the Patient confined to bed, bedroom or house by your directions? Yes ☐ No ☐

9b. Has the Patient at any time been so confined since the date of the Accident / Illness? If so, please provide dates

10. If so still confined, plerase state:

10a. Your opinion as to the probable duration of such confinement?

Probable date of being able to resume some portion of usual business or occupation?

11. Are you prepared to certify that your Patient is TOTALLY disabled from attending to any portion of his / her business or occupation?

Yes ☐ No ☐

***(TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the Patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind.)***

12. If Patient has been able to attend to a PORTION only of his / her usual business or occupation, and if this still continues, please state since when (i) and also the probable date of recovery (ii).

(i) (i)

***(TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness does not wholly prevent the Patient from attending to business, or when Temporary Total Disablement ceases and he / she can attend to some portion of his / her usual business or occupation, but not the whole.)***



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13. If Patient has recovered, please state date of recovery.

GENERAL REMARKS

I certify that the aforegoing statements are correct:

Name: _____ Qualifications: _____

Address: _____

_____

_____ _____

Signature: Date: