Life Assurance

Critical Illness Claim Form By Medical Attendant

Group Life

Original copy – Insurer

Please complete in block letters or tick appropriate box, unless otherwise indicated

Medical Certificate

Patient's full names

When were you first consulted for the current illness?

When were you last consulted for the current illness?

When is the next appointment scheduled with the patient?

Was the patient referred to you? ☐ YES ☐ NO

Name of the doctor who referred the patient

Doctor's speciality | Doctor's tel. number:

History of critical illness event

What is the patient's diagnosis?

Date that the diagnosis was confirmed ☐☐☐☐☐☐☐☐

What were your findings on initial consultation (signs, symptoms, investigations)?

Please detail all treatment/interventions to date

Current status of critical illness event

At the time of your most recent consultation, how did the life assured present (signs, symptoms, etc)

What further treatment intervention is envisaged?

Please attach copies of results for all special investigations performed

Acknowledgment by attending doctor

I certify that the above information is, to best of my knowledge and belief, true and accurate and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's full name			
Registration number			
Physical location			
Telephone Number		Postal address	
Email address			

Doctor's signature		Date (**ddmmyyyy**)								

Doctor's stamp