



American Home Assurance Company

ARBN 007 483 267

(Incorporated with Limited Liability in the USA)

A Member Insurance Company of American International Group

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ATTENDING PHYSICIANS STATEMENT THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY	REFERENCE NUMBER
	POLICY NUMBER (with Prefix)
	SEX: M. or F. AGE:

PATIENT'S NAME AND ADDRESS

.....

WHAT IS DISABLING PATIENT?.....

Please give a complete diagnosis of this condition.....

.....

.....

.....

HISTORY:

1. When did patient first receive medical treatment?

2. (a) Was there a previous history of this or a similar condition? Yes/No.....

(b) If Yes, please state condition and advise when previous treatment was given.....

.....

.....

3. (a) How long have you known the patient?

(b) Are you the regular general practitioner? Yes/No..... If not, please advise who is

.....

IF INJURY:

1. When did patient suffer the injury?

2. What were the circumstances surrounding the injury?

IF SICKNESS:

1. When was sickness first contracted?

2. When did symptoms become evident?

DEGREE OF DISABILITY:

1. Patient's Occupation?.....

2. When was patient obliged to cease work?.....

3. If Patient is still disabled, when approximately will the patient be able to resume:

(a) Some Duties?

OR (b) Full duties?

4. If patient has recovered, when was patient able to resume:

(a) Some Duties?

(b) Full duties?

PLEASE TURN OVER

