Medical Certificate For Disability

Name of the Member: _____ Group Policy Number: | | | | | | | | | | | | | | |

Name of the Group Policyholder: _____

CLAIMANT'S DETAILS

Full Name of Claimant: _____

Date of Birth: D D M M Y Y Y Y Policy No.: | | | | | | | | | | | | | |

Telephone Number: | | | | | | | | | | |

Occupation (including description of duties): _____

_____

Qualification: _____ Last day at work: _____

Medical History

1. Diagnosis and reason for claim: _____

   _____

2. Date when the symptoms started (Duration of illness): _____
3. Date when Life Insured first seen by you for this reason: _____
4. Date when Life Insured stopped work: _____
5. Date when Life Insured was seen by you for any other conditions (please give dates and details below) _____

   _____

Date	Reason for Consultation	Treatment Prescribed	Duration of Complaint
D D M M Y Y Y Y			

Medical References

Please give the details of any other Practitioners, Specialists or Hospitals to who the claimant has been referred. Please include copies of all available Specialist reports

Name of Practitioner / Hospital	
Address	
Contact no										
Speciality	
Postal Address	
Complaints referred for	
Date of Referral	

Medical History

Please give full medical history, including the following.

- Symptoms and diagnoses
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. lung function readings, X-ray or scan results)
- Treatment and response
- Other comments

Current major complaint (s)

Please comment on the member's ability to carry out the specified activities in the table below.

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self and others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly and making							
decisions							
Interacting with others							
Walking (non-strenuous)							
over level ground							
Walking (strenuous) over							
uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Use of both arms and legs							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							
Bathing							
Dressing							
Getting in and out of bed							
Maintaining personal hygiene							
Feeding onself							
Getting between rooms							

Results Of Most Recent Medical Examination

Date of Examination: D D M M Y Y Y Y

Please give full clinical details as at the examination, including height, weight, and blood pressure readings. Please include details of any limitations evident at the examination (e.g. joint limitations, visual acuities).

PROGNOSIS

What are chances of recovery Good/Fair/Poor/Nil)?

Are any residual problems likely? Please specify:

Date expected to return to work: D D M M Y Y Y Y

Does The Claimant Use Tobacco In Any Form? ☐ Yes ☐ No

If "yes" please provide details:

Is Current Medical Impairment Due To:

a) Previous illness or injury ☐ Yes ☐ No

b) The intentional consumption of alcohol, narcotics or any toxic substance ☐ Yes ☐ No

c) Attempted suicide or any self-inflicted injury ☐ Yes ☐ No

General comments, which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated.

If period off work longer than usually expected for impairment, please give reason.

Treatment And Rehabilitation

Current treatment regime. Please specify all medications and dosages:

Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy):

Planned future treatment, including surgery:

Your recommendations regarding rehabilitation (if applicable)

Name of Doctor: Registration Number:

Name of the Hospital:

Postal Address:

Landline No.: Mobile No.:

Email address: Qualification:

Registration Number:

Declaration:

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals and complete and that any information that could influence a decision regarding this claims, has not been withheld. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in relation to the above policy.

Full Signature of Doctor:

Date of report: D D M M Y Y Y Y

Any confidential information, which in your opinion should be in the possession of the Company, should be forwarded to Head Office at the below mentioned address.

FOR/1/17-18/1442