



Applicant : \_\_\_\_\_

Policyholder: \_\_\_\_\_

Group Number: \_\_\_\_\_

### ATTENDING PHYSICIAN'S STATEMENT - UNDERWRITING INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear Doctor:

The above named individual, who has applied for insurance with this Company, states that you have examined or treated him or her in the past. May we have a brief report of your findings, diagnosis, and results of your treatment? This information will be considered confidential and privileged. Thank you so much for your help.

Dates Attended Month Year	Complaints & Abnormal Physical Findings	Duration of Illness	Diagnosis	Describe Treatment or Operation

1) Most current Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure reading \_\_\_\_\_

2) Does the patient smoke cigarettes? If yes, please indicate number of cigarettes smoked per day.

3) Laboratory Findings (including x-ray, ECG, BMR and pathological reports, etc. with dates)

4) Present condition, if known? (Indicate sequelae and complications of above reported illnesses)

5) Have any other physicians or surgeons been consulted? If so, please give name, date, and nature of disorder.

6) Please record any other information which might have a bearing on this person's health.

7) How long have you treated this patient?

Date \_\_\_\_\_ Signature \_\_\_\_\_ M.D.