Accidental Injury
Hospital Cash Claim (Accident or Sickness)
Attending Physician's Statement

Form 'D'

INSURED INFORMATION

Insured's Name_____ **Date of Birth** ____/____/___ **Marital Status** _____

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Name and address of employer _____

Policy Number_____ **Insured's Occupation** _____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries,

_____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Was the Insured hospitalized? _____ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: _____

_____

Were any surgical procedures performed? _____ **If yes, please list all procedures, and dates performed:**

_____

_____

What are the Insured's current subjective symptoms? _____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? _____

_____

Dates of total disability: **Dates of partial disability:**

From: _____/_____/_____ **To:** ____/____/____ **From:** _____/_____/_____ **To:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____ **If yes, please list the names and addresses of all other physicians:** _____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ **Phone No.** _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____ **DATE** ____/____/____