I.M.E. LIFE INSURANCE COMPANY LTD.

Hathway Complex, Lainchour-26 Kathmandu, Nepal
Phone No: 4024071, Fax No: 4024075

PHYSICIAN'S STATEMENT FOR CRITICAL ILLNESS

Please complete this form as fully possible. Your kind assistance will help expedite our claim settlement.

Name of patient: ..... Policy No.: .....
Gender: ❑ Male ❑ Female Date of Birth: .....
Address: ..... Telephone No.: .....

Are you the patients regular Physician? ☐ Yes ☐ No
If yes, since when (date)? .....
If the patient was referred from a clinic or hospital, please state:
i. Name of Physician.....
ii. Name of clinic /hospital .....
iii. Date Referred .....

1. CONSULTATION FOR PRESENT CRITICAL ILLNESS

a) Describe the type of Illness/Critical Illness.....
b) Date of first consultation for this Illness/Critical illness .....
c) Date of diagnosis .....
d) Hospital/Lab of diagnosis .....
e) Please mention the symptoms of this Illness/ Critical Illness.
.....
.....
f) Have patient previously suffered from a similar or related health condition? ❑ Yes ❑ No
If "Yes", please provide dates and details of illness:
.....
g) Have patient undergone or undergoing any tests or treatments of the diagnosed illness ❑ Yes ❑ No
If "Yes", please provide dates and details:
.....
.....

h) If patient has undergone /undergoing any tests or treatments related to the diagnosis at a hospital or similar institution, please provide the following information:

Name and address of Hospital/Institution	Reason of admission	Date of Admission	Date of Discharge
.....	.....	.....	.....
.....	.....	.....	.....

2. PATIENT'S CONDITION

Please describe the nature and severity of the patient:

a) Present condition of the patient due to illness/Critical Illness.....
b) Is the Illness/Critical Illness progressive, stationary or improving?
.....
c) To what extend does the Illness/Critical Illness prevent him from performing all the normal duties of the usual occupation?
.....
d) Please describe treatment, including any surgical operations amputation performed.
.....
e) Has Patient been admitted to hospital before for the same illness? If yes please state: .....
i) Name and Address of hospital .....
ii) Date of Admission .....
iii) Date of Discharge .....
iv) Complaints admitted with .....
f) Has the patient suffered or is suffering from any other disease or aliment? If so, please give details:
.....

3. ILLNESS/CRITICAL ILLNESS

a) Does the Illness/Critical Illness fulfill the criteria of the mentioned illness? If yes, which one

……

……

b) If no, then does it fall under the following illness conditions?

……

……

c) Please provide us with if any other additional information including neurological examinations laboratory tests, X-Ray etc. that will enable the company to assess this claim.

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DECLARATION

Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties.

I, ... verify that the above statements are true and complete to the best of my knowledge and belief.

……

Signature of Physician

Name: ……

Qualification: ……

Regd. No.: ……

Date: ……