CLAIM FORM
Physician's Report In Case of Disability Assessment

PACIFIC CROSS

Please complete this form by a licensed doctor. The insured is responsible for the incurred fees.

1	Insured's First names - Surname :	Age : ..... Height : ..... Weight : .....
1.1	For Accident	Date of accident : ...../...../..... Time : ..... hrs.
1.2	For Illness	The duration of the illness : .....
2	Specify the cause and severity of the disability :	
3	Please specify the results of the neurological, laboratory and X-ray examinations or other special tests :	
4	Please specify the treatment the insured has received since the disability began. :	
5	Diagnosis :	
6	Complications :	
7	You have treated the patient from : ..... to ..... At : ..... Type of treatment :	

8 Physical examination

8.1	Strength of Muscle	Arm	Right Grade: 0 I II III IV V Left Grade: 0 I II III IV V	Leg	Right Grade: 0 I II III IV V Left Grade: 0 I II III IV V	
8.2	Consciousness	◯ Conscious	◯ Confused	◯ Drowsy	◯ Unconscious	
8.3	Hearing ability	◯ Normal	◯ Difficult	◯ No		
8.4	Speech ability	◯ Normal	◯ Difficult	◯ No		
8.5	Daily activity ability	◯ By him / herself	◯ By him / herself with assistance of other	◯ No		
8.6	Walking ability / mobility	◯ By him / herself	◯ By him / herself with supporting equipment	◯ No		
8.7	Work performance ability	◯ Yes	◯ Yes, only in a suitable environment	◯ No		
8.8	Type of disability	◯ Temporary Total Disability	◯ Permanent Partial Disability	◯ Permanent Total Disability		
8.9	Prognosis	◯ Improve	◯ Unchanged	◯ Worse		
8.10	Additional opinion	.....				

Physician's Name : ..... Signature : .....

License No.	..... (Completion is Compulsory)	Degree	.....	Certificate / Approved Card/ Branch	.....
Hospital's Name	.....	Telephone No.	.....	Date of examination	.....

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