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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