International Healthcare

Disability Claim Form

Personal reference no.:

To be completed by the attending doctor at the Insured or Owner's expense
Important note :
Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this questionnaire with as much detail as you can possibly provide. Your kind assistance will help expedite the claim settlement.

1. Patient's details

Full name of patient	Patient's HKID / Passport No.	Date of birth (dd/mm/yyyy)

2. Known history with patient

Date for first consultation (dd/mm/yyyy)	
Name and address of doctor who has referred this patient to you for this injury or illness:	

3. About the disability

Please state cause of the disability

❑ Due to an illness

Diagnosis	Date of diagnosis	Date of the first consultation for this condition	Symptoms presented during the first consultation

❑ Due to an accident

Date, time and details of incident	Signs of bodily injury e.g. bruise or wound

Was the disability related to the following condition?

Recurrent episode	❑ Yes	❑ No
Self infliction	❑ Yes	❑ No
Influence by alcohol or drugs	❑ Yes	❑ No
Chronic illness	❑ Yes	❑ No

If answer is "Yes", please provide details

4. Treatment for disability

Consultation or treatment at clinic or hospital

Consultation date or hospital admission date	Name of doctor or hospital	Complaints and symptoms	Diagnosis	Treatments given (please state name of surgical procedure if it had been or will be

Date of surgery	Name of surgery	Diagnostic tool	Results of any histopathological study

5. Progress of recovery

Date of last consultation	Physical findings	Treatments	Indication for follow-up

Note:
1. **Total disability** refers to inability to perform all job duties.
2. **Partial disability** refers to inability to perform some job duties.
3. **Permanent total disability** refers to inability to perform any gainful occupations.

Period of total disability	From _____ To _____ Reason
Period of partial disability	From _____ To _____ Reason
Period of permanent total disability	From _____ To _____ Reason

Current physical or mental impairment	Factors that may have contributed or lengthened the period of disability

Is the patient currently UNABLE to perform any Activities of Daily Living (ADL)? (Please tick ✓)

Ability to feed oneself	❑ Yes	❑ No
Ability to wash and bathe oneself	❑ Yes	❑ No
Ability to dress and / or undress onself	❑ Yes	❑ No
Ability to attend to own toilet needs	❑ Yes	❑ No
Ability to move independently in and out of bed or chair	❑ Yes	❑ No
Ability to move indoors from room to room on level surface	❑ Yes	❑ No

If answer is "Yes", please provide details

If the patient is still unable to return to regular occupation, what is the future treatment / rehabilitation plan? And what is the expected date he / she may engage in any other occupation?

6. Declaration and agreement

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration on this claim form.

Name of Physician	Contact tel. no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date

Please send this claim form back to your insurance broker or directly to the Insurer's representative :

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