ARGUS
Our Interest is You.

Attending Physician's Statement of Disability

Bermuda Life Insurance Company Limited

A. Information

Last Name of Patient	First Name of Patient	Middle Initial

Mailing Address

Date of Birth (MM/DD/YY)

Employer

Employer's Address

Are you the patient's usual medical attendant?

If yes, how long have you been his/her private medical attendant?

What date do your records commence? (MM/DD/YY)

B. Statement of Disability

1. Precise diagnosis of present disability

2. History
a. Date symptoms first appeared or accident happened (MM/DD/YY)
b. Date patient ceased work due to illness (MM/DD/YY)

c. Has patient ever had same or similar condition?	If yes, when (MM/DD/YY)
☐ Yes ☐ No	

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3. Present Condition		
a. Results of all tests carried out (x-rays, EKGs, etc.). Please indicate if patient will undergo further tests or examinations		
b. Is patient (Please check one)		
☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined ☐ Other		
If other, please explain		
c. Does the interruption of work also result from any of the following problems?		
☐ Marital/family issues ☐ Personal or interpersonal issues ☐ Alcohol or drug abuse ☐ Professional ☐ Loss of employment or layoff ☐ Other		
If other, please explain		
4. Treatment		
a. Date of first visit (MM/DD/YY)		
b. Date of last visit (MM/DD/YY)		
c. Frequency of visits		
d. When did you last examine the patient? (MM/DD/YY)		
e. Drugs (name and dosage)		
f. Consultation with specialist? (If yes, please indicate date and name and attach a copy of the consultation report, if available)		
g. Surgery (date and procedure)		
h. Hospitalisation		
From:	To:	Hospital:
i. Other treatments, specify		

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5. Progress (Please check one)
☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐ Other
If Other, please explain
6. Extent of disability
a. Has your patient returned to work?
☐ Yes ☐ No
If yes, please provide date (MM/DD/YY)
b. If patient has not returned to work
(i) what are the patient's current symptoms and limitations? Please provide information on the functional restrictions that prevent him/her from working
(ii) when will patient be able to return to his/her regular occupation? (MM/DD/YY)
(iii) should your patient return to work on a gradual basis?
☐ Yes ☐ No
If so, please provide a suggested progression schedule and a date of full return to work
(iv) is patient a suitable candidate for a rehabilitation programme?
☐ Yes ☐ No
If yes, what type of program would be appropriate?
7. Mental condition
In your opinion, is patient competent to endorse cheques and direct the use of the proceeds thereof?
Further Information
Please include any further information, which you feel would be helpful in the assessment of your patient's disability
Please provide copies or an extract of copies of all hospital, consultations or diagnostic reports that would be helpful in the consideration of this disability claim. If you would prefer, you may forward the originals, which will be returned to you promptly.

Physician's Name *(please print)* | Attending Physician's Signature | Date (MM/DD/YY)