RESET / CLEAR FORM

PARAMOUNT
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ACCIDENTAL INDEMNITY FORM 2

CERTIFICATE OF ATTENDING PHYSICIAN

Policyholder/Creditor : _____ Claim: _____

Master Policy No : _____ Policy/Certificate No : _____

1. a. Name of Claimant : _____
   b. Residence Address : _____
   c. Present Occupation : _____

2. a. Describe fully the particulars of the accident and how it occurred : _____
   Date : _____ Time : _____ ☐ AM | ☐ PM Place : _____
   Cause of the accident : _____
   b. Did the accident occur during performance of the occupation? ☐ YES | ☐ NO If yes, describe fully :
   _____
   _____
   c. What was the nature of the Claimant's occupation immediately prior to the accident? _____
   _____
   _____
   d. How long after the accident did you see the victim-claimant?
   Where did you see him/her? _____

3. a. State fully the exact nature and extent of the injuries sustained. If to arm, leg or eye, state whether RIGHT or LEFT :
   _____
   _____
   b. Are the injuries and their present conditions sufficiently accounted for by the description of the accident given on the Certificate of Claimant? ☐ YES | ☐ NO If not, what is your opinion?
   _____
   _____

4. a. TOTAL DISABILITY – State whether the patient is confined to the hospital/house and prevented from pursuing his usual business or occupation as a direct result of his injuries. Give details. _____
   _____
   _____
   b. PATIAL DISABILITY – State whether he is up and about and able to perform some of the duties of his business or occupation. Give details. _____
   _____
   _____
   c. State how long in your opinion the claimant will be so disabled.
   TOTAL DISABILITY : From _____ to _____
   PARTIAL DISABILITY : From _____ to _____

5. a. How would you classify his disability? ☐Total Permanent ☐Partial Permanent ☐Total Temporary ☐Partial Temporary
   b. If partial, what in your opinion is the degree of incapacity? _____

6. a. State the nature of treatment given to, or surgical operation performed on the victim since the accident :
   Nature of treatment: _____ By whom: _____
   When : _____ Where : _____

b. Describe briefly the patient's present condition and what after effects there are or could be expected, if any, as the sole and direct result of the accidental injury. _____

_____

7. Is the patient now or was he at the time of the accident suffering from or affected by any physical infirmity, disease or illness (cardiac, gout rheumatism or fits of any kind, etc.) which have contributed, directly or indirectly, to the occurrence of the accident ☐ YES | ☐ NO If yes give details :

_____

_____

8. In your opinion, was he under the influence of liquor or any other intoxicating drink or drug, at the time of accident? ☐ YES | ☐ NO

9. a. Are you the Claimant's regular physician? ☐ YES | ☐ NO How long have you known him? _____

_____

b. Have you attended him for any illness or accident? ☐ YES | ☐ NO If yes, what and when? _____

_____

c. Have you any reason to believe he has ever had a previous accident or that he has ever claimed upon any Accident Insurance Company? ☐ YES | ☐ NO If yes, state the reasons

_____

_____

d. Has he received treatment in any hospital, clinic or other institution? ☐ YES | ☐ NO If yes, give:

Name of Institutions	Attending Physicians
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I, _____ **hereby certify that the answers given above are full, complete and true, I am a**
(Printed name of Physician)

graduate of _____ **in the year** _____
(Medical College)

FRAUD WARNING

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

Date and signed at _____ on _____ year _____

_____

_____

_____

_____
Full Address of Physician

_____
Physician's Signature

PRC NO. _____

Date Issued : _____

Place Issued : _____