PROOF OF SICKNESS Submitted to

MetLife

CRITICAL ILLNESS/DISABILITY

American Life Insurance Company
(Incorporated in USA, Nepal Regn. No. 6/062/063)
Narayani Complex, Pulchowk
P.O. Box 11590,Kathmandu, Nepal
Tel: +977-1-5555166, Fax: +977-1-5555173

THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient ..... Age .....

Nature of Sickness or injury (Describe) .....

When did symptoms first appear or accident happen? Date .....

Is there visible evidence of contusion or wound? Describe .....

Was the patient at time of this accident or during this disability, affected with any previous injury or any other disease? Yes ❑ No ❑

(If "Yes", state when and describe) .....

Nature of surgical or obstetrical procedure, if any (Describe fully) .....

Is further operative procedure or treatment anticipated? Yes ❑ No ❑

(If "Yes", explain) .....

For what period was the patient

Hospital confined (if any)	From	To .....
House confined (if any)	From	To .....
Bed confined (if any)	From	To .....
Ambulatory (if any)	From	To .....

DIAGNOSIS……..Date of First Diagnosis……

If injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture of long bones occurred, state whether through head or shaft.

TREATMENT: Date of First Visit ..... Date of Last Visit ..... Total Number of Visit .....

DESCRIBE PRESENT CONDITION Indicate if recovered, improved, unimproved or retrogressed: .....

DEGREE & LENGTH OF DISABILITY (for accidental disability only):

From what dates has the patient been unable to perform any part of his occupation? (Totally Disabled) From .....To .....

From what dates has the patient been unable to perform some part but all of his occupation? (Partially Disabled)From…… .....To…….

If not working, when do you think he will able to work? Approximate Date ..... Indefinite ❑ Never ❑

I HEREBY CERTIFY THAT MY ANSWERS TO THE FOREGOING QUESTIONS ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF ATTENDING PHYSICIAN:…….

NAME:…….. NMC NO……

DATE:……. OFFICE SEAL

EMPLOYER'S STATEMENT

Name and Business Address of Insured's Employer ……

Full Name of Insured .....

Insured's duties .....

When was Insured compelled to give up his/her duties? (Exact Date) ..... When did Insured return to work? (Exact Date) .....

Description of Injury or Illness resulting in Insured's absence from employment .....

Was Injury or Illness caused by reason of occupation? Yes ❑ No ❑

Was there a period of time during which Insured could only perform part of his occupational duties? (Exact Date) .....

Was insured's Injury or Illness the sole cause of his absence from duty for all of the above period? .....

If not, give particulars .....

SIGNATURE .....
NAME: .....
DESIGNATION.....
DATE: ..... OFFICE SEAL