Attending Physician Certification for Waiver of Premium

Patient Information

Name of Patient

Date of Birth

Policy Number

Claim/Reference No.

Medical Certification

Diagnosis (Primary and Secondary)

Date Symptoms First Appeared

Date of First Consultation

Date of Diagnosis

Is the condition due to accident or illness?

Describe Nature and Extent of Disability

Date Patient Became Totally Disabled

Estimated Duration of Total Disability

Is Patient Currently Under Your Care?

If No, Give Last Date Seen

Treatment & Medications

Other Physicians/Clinics Involved

Physician's Certification

Physician's Name

License Number

Specialization

Contact Number

Address

Signature of Physician

Date