Physicianâ€™s Statement Form

Term Life Insurance Assessment

1. Patient Information

Full Name

Date of Birth

Policy/Application No.

Address

Phone Number

Gender

2. Medical History

Presenting Condition(s) & Diagnosis

Date of First Consultation regarding this condition

Details of Medical History (including duration, symptoms, relevant investigations)

Current Treatment & Medications

Other Significant Medical Conditions (if any)

3. Physical Examination

Height

e.g. 175 cm

Weight

e.g. 70 kg

Blood Pressure

e.g. 120/80 mmHg

Examination Findings

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4. Physician's Assessment

Prognosis & Comments (including any limitations or restrictions)

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5. Physician Details & Declaration

Full Name

Medical Registration No.

Clinic/Hospital Name & Address

Phone

Date

Signature