Policy No.:
Claim No.:

Tata AIA Life Insurance Company Limited

(hereinafter called "Tata AIA", whichever is applicable)

TOTAL & PERMANENT DISABILITY CLAIM FORM (ATTENDING PHYSICIAN'S MEDICAL REPORT)

To be completed in BLOCK letters by a duly qualified & registered medical practitioner at the claimant's expense. Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.

Insured's name	Identity Card No.	Age	Sex
Occupation & duties of Insured declared to you			

(A) HISTORY & DIAGNOSIS

The date when symptoms first appeared or accident happened	____ DD ____ MM _____ YYYY	Symptoms and complaints presented by the Insured	
The date of first consultation	____ DD ____ MM _____ YYYY	Clinical and physical findings during first consultation	
The date when the diagnosis was given	____ DD ____ MM _____ YYYY	The diagnosis of the condition and its complications	
The date when the Insured first absent from work due to the condition	____ DD ____ MM _____ YYYY	Has patient ever had same or similar condition? If so, please state when and give details.	

Details of consultations and treatment rendered by you

Date/Period	Details of Treatment	Tests/Investigation/Surgical Procedures	Result

Name and address of other doctors/hospitals attended for treatment of this or similar condition

Date/Period	Condition	Physician/Hospital attended	Address

(B) CURRENT HEALTH OF THE INSURED

Progress of recovery	□Recovered □ Improving □ Static □ Retrogressed Remarks :
Current state of mobility. Give name of hospital and the period of hospital confinement, if any	□Ambulatory □ Home confined □ Bed confined □Hospital confined Remarks :

Please describe the current physical impairment	
With the current health condition of the Insured in mind, what would you rate the present working capacity of the insured?	□ No limitation of functional capacity, capable of heavy work without restrictions □ Capable of medium manual activity □ Slight limitation of functional capacity, capable of light work □ Moderate limitation of functional capacity, capable of clerical / administrative activity □ Severe limitation of functional capacity, incapable of minimum activity Remarks :
Please describe the current mental impairment of the Insured (if normal, please go to Part D)	
With the current mental status of the Insured as described above, what would you rate the present ability for interpersonal relations and communication of the insured?	□ Able to engage in all interpersonal relations and communication (without limitations) □ Able to engage in most interpersonal relations and communication (slight limitations) □ Able to engage in only limited interpersonal relations and communication (moderate limitations) □ Unable to engage in interpersonal relations and communication (marked limitations) □ Has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks :

(C) PROGNOSIS & REHABILITATION

Is the insured now totally disabled?	In terms of his/her own job □ Yes □ No	In terms of any other job □ Yes □ No
What duties of the Insured's job is he/she incapable of performing?		
Do you expect a fundamental or marked change of this present condition in the future?	□ Yes □ No	
If yes, how long do you expect the Insured will take to perform duties?	In terms of own job □ Within 1 Mth □ 1-3 Mths □ 3-6 Mths □ 6-12 Mths □ > 12Mths □ Never Remarks :	In terms of any other job □ Within 1 Mth □ 1-3 Mths □ 3-6 Mths □ 6-12 Mths □ >12Mths □ Never Remarks :
If no, please explain		
Please state any further treatment/rehabilitation plan		

(D) MISCELLANEOUS

If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	
Can our Medical Director and/or claim assessor release the information provided by you in this report to the patient when we are requested to explain our claim decision?	□ Yes □ No

I hereby declare that I have personally examined and treated the insured in connection to the above disability and that the facts as given above are true and complete to the best of my knowledge and belief.

Name of Physician _____ Signature _____

Qualifications _____

Registration No. & Place _____ Chop _____

Address _____ Telephone _____

_____

_____