THE MARITIME FINANCIAL GROUP

Maritime Life (Caribbean) Ltd.
P.O. Box 710, Port-of-Spain

ADmed STATEMENT OF ATTENDING PHYSICIAN OR SURGEON

(The fee for this statement is the responsibility of the insured)

Name of Patient: _____ Policy No: _____

Date of Birth: _____

The above named is insured with MARITIME LIFE (CARIBBEAN) LIMITED against the occurrence of certain contingent events associated with his/her health. We would be grateful for your co-operation in the completion of this form to enable us to assess claim and make the prompt settlement.

THE ISSUE OF THIS FORM IS IN NO WAY AN ADMISSION OF LIABILITY

	A. MEDICAL DETAILS:			
1.	Please provide full and exact details of the condition (describe any complications).			
	Please give details of any YES answers			
		YES	**NO**	**DETAILS**
2.	Was this (a) an Accident?			
	(b) an Emergency?			
3.	Is there any evidence/history of:			
	a) Alcohol Abuse?			
	b) Drug Addiction?			
	c) Smoking?			
4.	Is there any disease or infirmity affecting present condition?			
5.	a) Please give the details of any tests or investigations recommended by you.			
	b) Are the tests requested for the purpose of obtaining a diagnosis?			
6.	Was surgery performed? *(If YES, please give name of procedure and date)*			
7.	Is it likely that the patient will have to undergo further treatment in connection with this illness/injury? *(If YES, please give details (including laboratory investigations/X-rays/others).*			

	B. GENERAL			
1.	Are you the usual medical doctor? *(If YES, over what period do your records extend?)*			
2.	When were you first consulted for this condition?			
3.	At that time, how long had the symptoms been present?			
4.	Was the patient informed of the diagnosis? *(If YES, please give date)*			
5.	Has the patient previously suffered from the condition specified above or related illness? *(If YES, please give details)*			
6.	Please give the name and address of all consultants, specialists or hospitals to whom your patient has been referred or attended for this condition.			

NAME	ADDRESS	DATE OF ADMISSION/ CONSULTATION	DATE OF DISCHARGE

C. ADMED BENEFITS

In order for a claim to be payable at least one of the following definitions must apply:

SURGICAL BENEFIT:

The surgical operation must be (a) medically necessary and appropriate, (b) an invasive procedure requiring a surgical incision; and (c) must be performed at a hospital.

HOSPITAL DIAGNOSTICS BENEFIT:

The expenses were incurred as a result of accident, emergency or for sickness on an approved doctor's recommendation at a hospital in respect of the diagnosis of an Injury, condition or disease.

ACCIDENT & EMERGENCY BENEFIT:

The expenses incurred at a hospital in respect of accident or emergency services or in respect of ambulance services required as a result of an accident or emergency.

- Under this benefit **Accident** is defined as:

Any sudden and unforeseen event occurring during the policy period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control and for which initial treatment is sought within seven (7) days of the accident.

- Under this benefit **Emergency** is defined as:

The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient's health In serious jeopardy;
- serious Impairment to bodily functions; or
- serious dysfunction of any body organ or part.

	YES	NO	
In your opinion, has one of the definitions stated been satisfied? ❑ Surgical ❑ Hospital Diagnostics ❑ Accident & Emergency			

DOCTOR'S NAME (PRINTED)

ADDRESS:

DATE:

PRACTICE STAMP:

SIGNATURE