

LOSS OF USE - CONFIDENTIAL PHYSICIAN'S REPORT LOSS OF INDEPENDENT EXISTENCE

PERSONAL DETAILS						
INSURED	<table border="1" style="width: 100%; height: 15px;"> <tr> <td style="width: 50%; text-align: center; font-size: 8px;">First Name</td> <td style="width: 50%; text-align: center; font-size: 8px;">Middle Name</td> </tr> </table>	First Name	Middle Name	<table border="1" style="width: 100%; height: 15px;"> <tr> <td style="width: 100%; text-align: center; font-size: 8px;">Last Name</td> </tr> </table>	Last Name	
First Name	Middle Name					
Last Name						
ADDRESS:						
	No.	street	city	country		
MAILING						
	No.	street	city	country		
PHONE NO: (____) _____						
	country code	number	DATE OF BIRTH: ____/____/____			
			month	day	year	

In order for a claim for loss of Independent Existence to be paid under this Loss of Use benefit, the following definition must be satisfied:

Loss of Independent Existence means (A) being totally and permanently unable to perform, by oneself, at least three (3) Of the following six (6) Activities of Daily Living, for a continuous period of six (6) months, with no reasonable chance of recovery.Or (B) Cognitive Impairment.

Six (6) Activities of Daily Living

- Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting - the ability to get to and from the toilet and maintain personal hygiene.
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding - the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils

Or Cognitive Impairment

- Mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which is measurable and results from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe as to require continuous daily supervision.
- Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.
- A mental or nervous disorder without a demonstrable organic cause is not covered

Loss of Use shall mean permanent, total and irrecoverable loss of use, beyond remedy by surgical or other means

1. (a) On what date did your patient first consult you for Loss of Independent Existence.

- (b) How long has the insured been your patient?

2. On what date did your patient first have symptoms or suffered Loss of Independent Existence? Please provide details.

3. (a) Please provide details, including dates, of the injury or disease causing loss.

- (b) Is the loss permanent and irreversible.

- (c) Please describe the degree of Loss of Independent Existence.

4. Were there any associated neurological or psychological complications including hysterical aphonia?

5. Please indicate duration of Loss of Independent Existence.

6. Has there been any improvement since the onset of the condition?

7. What investigations or tests have been performed to verify the diagnosis of permanent Loss of Independent Existence.

8. Has your patient suffered any previous episodes of Loss of Independent Existence or any condition leading or related to it?

9. Please describe, including dates, any predisposing conditions or risk factors relating to the underlying cause of the Loss of Independent Existence.

10. Please provide names and addresses of other physicians or speech language therapists consulted or hospitals attended by your patient for this condition.

11. Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports for our Consultant's review within the last six (6) months..

Our contract requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient: Yes No

Signature: _____

Dated: _____

Name (in block capitals please): _____