INSURANCE COMPANY LIMITED
meeting your needs

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ATTENDING PHYSICIAN'S REPORT

(Please send directly to NCB Insurance in CONFIDENTIAL ENVELOPE provided)

Full name on record for Life Insured/patient: **Address (Residence):**			**Date of birth on record:** **Occupation:** **Employer:**		
Dates Attended	Reason for Consultation	Duration of Illness	Diagnosis	Describe Treatment, Medication, surgery etc.	Is he/she still on treatment?

Please provide additional information on page 2 of this form (**initial this page**)

Full name on record for Life Insured/patient:

Dates Attended	Reason for Consultation	Duration of Illness	Diagnosis	Describe Treatment, Medication, surgery etc.	Is he/she still on treatment?

Has the insured, to your knowledge, received any treatment during the last three (3) years from any other physician or in any hospital or institution? **Yes** **No**

If **yes**, please furnish the following:

Name of Physician/Institution **Address** **Nature of Illness or Injury** **Dates**

COMPLETE FOR TERMINALLY ILL PATIENTS ONLY

On what date was this patient first diagnosed as terminally ill? By whom?

Was this patient referred to you by another physician? If yes by whom?

Name of Physician/Medical Facility:	**Address:**
Physician's Signature *(affix stamp)***:**	**Date Report Completed**: