CONFIDENTIAL MEDICAL CERTIFICATE

BLINDNESS

Policy No : ……..…..…… Claim No : ……..……..……..…….

In order for a claim under this policy condition to be paid to the following definition must be satisfied :-

"**Total permanent and irreversible loss of all sight in both eyes.**"

PATIENT DETAILS

NAME : ……..…… OCCUPATION : ……..……..

ID CARD NO : ……..…… SEX : ……..…... AGE : ……

ADDRESS : ……..

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1. GENERAL

a) Are you the patient's usual medical attendant? YES ☐ NO ☐

If "yes", over what period do your records extend?

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b) When were you first consulted for the injury or condition causing blindness and, at the time, how long had symptoms been present?

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c) Has the patient previously suffered from the condition specified above or any related condition

YES ☐ NO ☐

If "yes", please state dates of consultations, and the resulting diagnosis.

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d) On what date did the patient become aware of the illness?

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e) Is there anything in the patient's habits or personal medical history which would have increased the risk of blindness?

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f) Have any of the patient's family (whether living or dead) suffered from eye disease including blindness cataract, glaucoma or retinitis pigmentosa?

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2. MEDICAL DETAILS

a) Please provide full and exact details of the injury or disease causing blindness, to include dates.

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b) Were there any associated systemic diseases?

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c) Is there any residual vision in either eye? YES ☐ NO ☐

If 'yes' please give details of the degree of vision (please express numerically where possible.)

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d) Is there any surgrey available that could re-instate vision in either or both eyes?

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e) Please confirm whether blindness in both eyes will be of a permanent nature.

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f) Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred, or attended for this condition.

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We would be grateful for copies of any relevant hospital reports that are available.

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3. If there is any further information which, in your opinion, will assist our Chief Medical Officer in assessing this claim, please give details.

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4. In your opinion, does the condition suffered by your patient fulfil the definition stated?

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Our Principal Medical Officer would be most grateful if you would send us copies of any specialist or hospital report/s together with any test/s, reading/s or similar evidence to support the validity of the patient's claim.

Hospital stamp Signatured ……..... Attending Physician Diploma ……..……...

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Licence NO …… Name of Hospital ……

Date ……..…… / …… / …….. City/Town ……..

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Tel. ……