BC Life & Health Insurance Company
Life Claims Unit
1350 Main Street
Springfield, MA 01103-1650

Statement of Attending Physician (Dismemberment)

Patient's Name ______________________________ Patient's Age ____________

On what date did you first examine and treat the patient?	Where?
Had patient previously had medical attention? If so, by whom?	
Describe the injury.	
Date of injury.	
What complications have arisen?	
What operation was performed?	Date
Name of surgeon	
If in hospital, which one?	From M. To M.
Was the injury described above, of itself, and independent of all other causes, sufficient to require amputation?	
Are you aware of patient having been medically or surgically treated at any time for any disorder, complaint or old injury affecting amputated limb? If so, what?	
To your knowledge, did patient ever have any constitutional or specific disease, either hereditary or acquired? If so, what?	
Was claimant under the influence of liquor at the time of your first visit?	
To what other companies or associations are you reporting this injury?	

Signed ______________________________ M.D.

Address ______________________________
STREET CITY STATE ZIP

Date ____________________

On chart on other side, please mark point of amputation.

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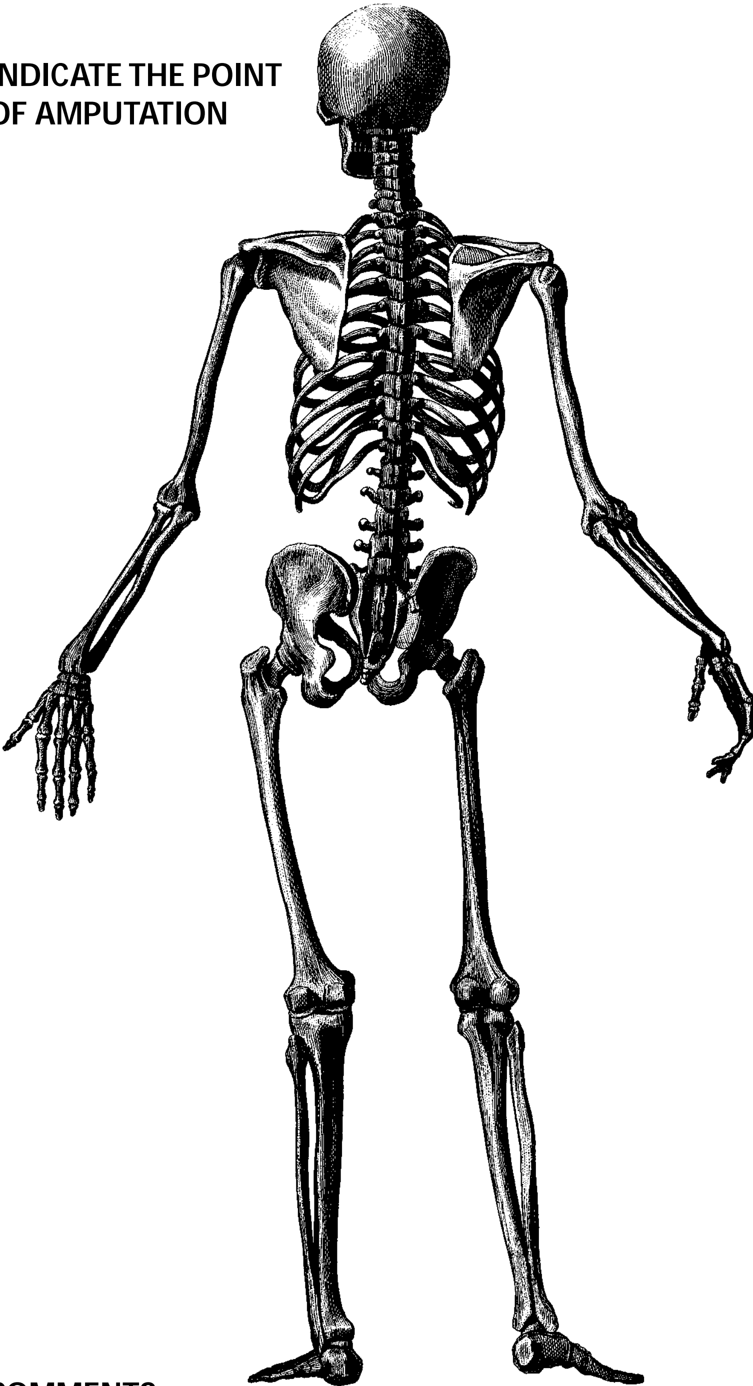
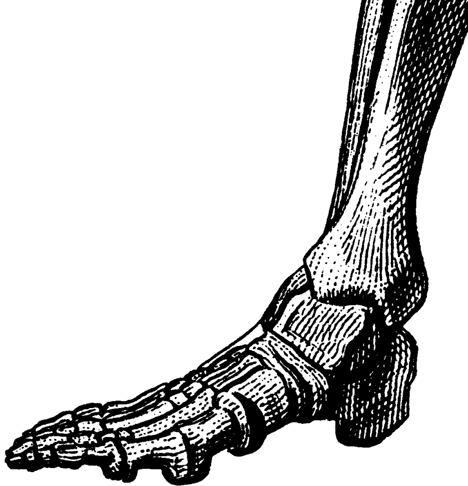
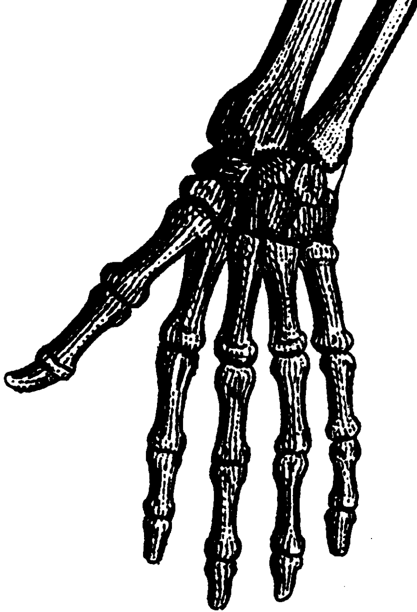
INDICATE THE POINT OF AMPUTATION







COMMENTS

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