

Attending Physician's Statement

OWNER NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
INSURED NAME:	POLICY NUMBER:	

Dear Doctor: _____

The above named is insured for certain Critical Illnesses by Oxford Life Insurance Company.
 A claim is being submitted in connection with this illness: _____

I authorize my attending physician to release medical information regarding my health status to Oxford Life Insurance Company for Verification of this Critical Illness.

 Signature of insured

 Date

 Address

 City, State, Zip

General Information regarding the critical illness

Are you the insured's attending physician? Yes ___ No ___, If yes, how long? _____

When were you first consulted for this condition? _____

When did the insured first have symptoms of this condition? _____

Has the insured ever had a similar or related condition before? Yes ___ No ___; if yes, please give dates and details of your treatment:

On what date did the insured become aware of this condition: _____

TREATMENT: Please provide details describing your treatment of the insured which resulted in a diagnosis of this illness _____

Name and address of the hospital where the insured was treated: _____

 Signature of Physician

 Date

 Address:

 Phone:

When replying, please include a complete copy of your office records