



BC Life & Health Insurance Company

Life Claims Service Center
PO Box 724767
Atlanta, GA 31139-1767

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.

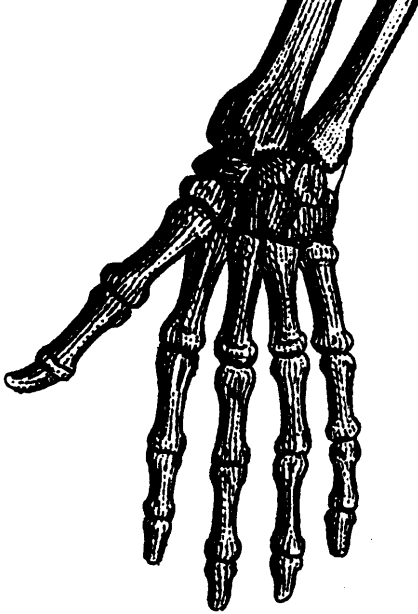
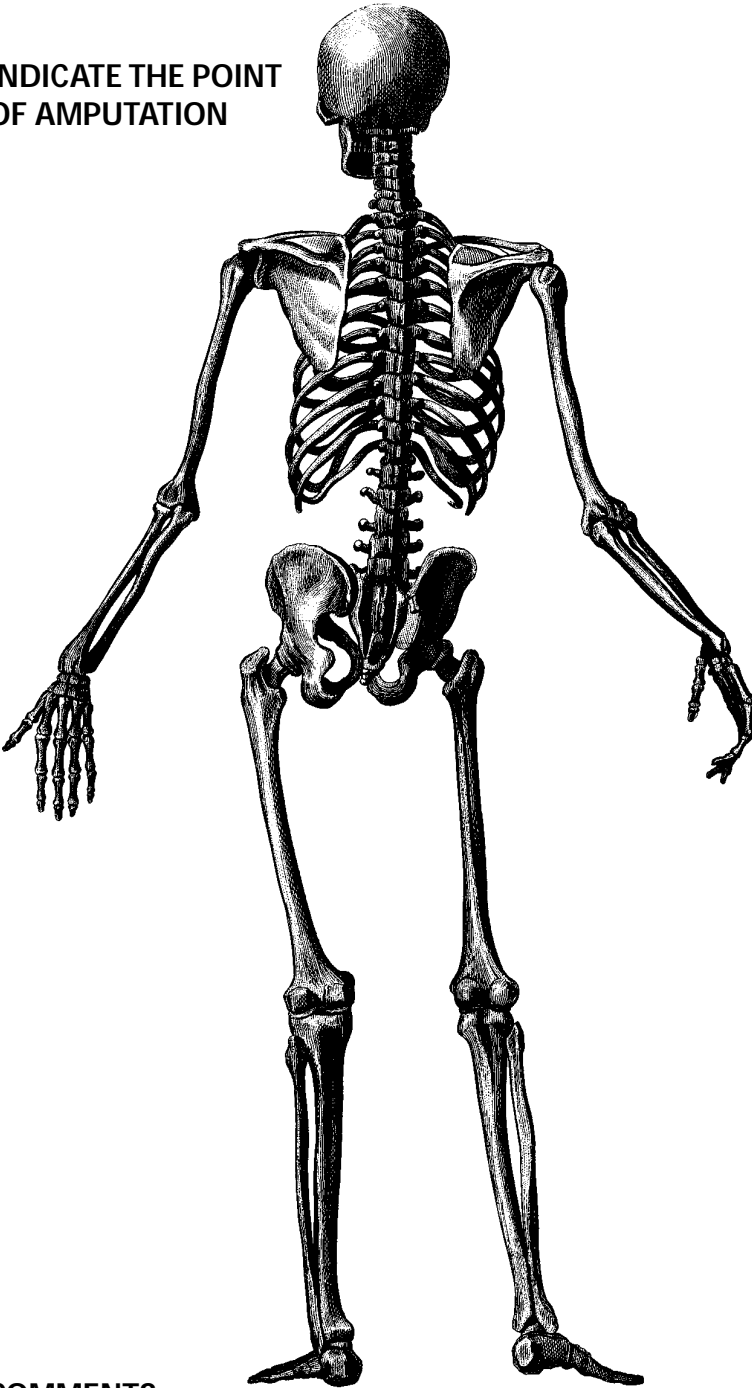
Address _____
STREET CITY STATE ZIP

Date _____

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

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(Dismemberment)

INDICATE THE POINT
OF AMPUTATION



COMMENTS
