Claim in case of dismemberment or loss of use

Physician's statement

Last name of patient:

First name of patient:

Date of birth: day / month / year

Phone number:

Please detail in case of dismemberment

1- Please attach the test results and a copy of your clinical notes and consultation reports.

Diagnosis

Date of the diagnosis day / month / year

Date of the accident (if applicable) day / month / year

Date of the amputation day / month / year

2- Please detail the specific joint level of the amputation and indicate on the following diagram.

3- What was the date of the patient's first visit for his/her current condition? day / month / year

4- Please detail the nature of treatments provided to this patient.

Please indicate the site of amputation

Limb loss

Right arm — Date day / month / year

Right leg — Date day / month / year

Left leg — Date day / month / year

Left arm — Date day / month / year

Right hand (dorsal view)

Right foot

4300-008-en
2018/06

To complete if there was loss of use

5- Total or definitive loss of use, please check the appropriate boxes.

Hand	☐ Yes	☐ No	Leg	☐ Yes	☐ No	Quadriplegia	☐ Yes	☐ No
Arm	☐ Yes	☐ No	Paraplegic	☐ Yes	☐ No			
Foot	☐ Yes	☐ No	Hemiplegia	☐ Yes	☐ No			

6- Total or definitive loss of use, please check the appropriate boxes.

Speech	☐ Yes	☐ No					
Vision	☐ Yes	☐ No	☐ Right eye	☐ Left eye			
Hearing	☐ Yes	☐ No	☐ Right ear	☐ Left ear	Is it a congenital condition?	☐ Yes	☐ No

7- Can vision, speech, or hearing be partially or completely covered by a device or a rehabilitation program? ☐ Yes ☐ No
If yes, specify ______________________

8- Is loss solely attributable to the above-mentioned condition or accident? ☐ Yes ☐ No
If not, specify any other cause at the origin of the loss:

____

____

To be completed if there has been loss of vision (please attach the report of the ophthalmologist)

9- Loss of vision

Did the accident cause a total loss of vision? ☐ Yes ☐ No

If yes, the loss affects:
- ☐ The both eyes
- ☐ The right eye only
- ☐ The left eye only

Date of loss of vision:

☐☐ / ☐☐ / ☐☐☐☐
day / month / year

In your opinion, the vision can be improved?
☐ Yes ☐ No

If yes, indicate how:
- ☐ By a treatment
- ☐ By an operation
- ☐ By wearing glasses

Is this loss permanent?
☐ Yes ☐ No

Please indicate what was the visual acuteness of the insured **before the accident**:

Right eye ______________________

Left eye ______________________
(Scale of Snellen)

Please indicate what is the **current** visual acuteness of the insured:

Right eye ______________________

Left eye ______________________
(Scale of Snellen)

To be completed if there has been loss of hearing (please attach the results of the audiogram)

10- Was there loss of hearing? ☐ one (1) ear ☐ two (2) ears

Hearing loss: low frequency limit ________ decibel

high frequency limit ________ decibel

Frequency used in the audiogram (for calculating averages): ________ hertz

11- Is this loss considered as total? ☐ Yes ☐ No **If yes**, since which date ☐☐ / ☐☐ / ☐☐☐☐
day / month / year

12- Is this loss permanent? ☐ Yes ☐ No

The ______________________ 20 ____ ______________________ M.D.
Print name

______________________ ______________________
Signature Address Phone No.

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