STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
Registered & Supervised by the Securities
& Exchange Commission of Pakistan
KARACHI SOUTHERN ZONE

Telephones : 2415051-59
Telegrams : BEEMAZINDAGI
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State Life Building No. 2, P. O. Box 4599, Wallace Road, Karachi-2.

PROOF OF CONTINUED DISABILITY FORM

POLICY No.

NOTE : This blank is furnished to the insured without prejudice to or waiver of the rights or defence that the State Life may have relative to any claim filed form hereunder.

Full Name of the insured.	(Print Ful Name)
Present Age of the insured	
Residential address of the insured.	
Occupation of the insured at the time of this accident	
Amount of insured's salary or wages. (If not employed on that basis, give average earnings)	
Period of total disablement of the insured solely by this injury for which insured could not attend to any part of the duties of his occupation.	From _____ 19 _____ at _____ O'Clock _____ M. From _____ 19 _____ at _____ O'Clock _____ M.
Did the insured visit his place of business during the period of total disability? If so, when and for what purpose?	
Period of partial disablement solely by this injury, for which the insured was unable to attend to certain important daily duties of his occupation? (Do not include any period of total disability in this)	From _____ 19 _____ at _____ O'Clock _____ M. From _____ 19 _____ at _____ O'Clock _____ M.
If partial disabiliy is claimed, state the particular duties the insured was unable to perfom during the entire period of partial disability?	
Has disability resulting from this accident ended and is this insured's complete claim?	

The above claimant being duly sworn, deposes and says that the foregiong statements are full and true to the best of his knowledge and belief.

SUBSCRIBED AND SWORN TO BEFORE ME

this ..... day of ..... 19.....

.....
(Signature and official seal of Notary, Justice of Peace or Magistrate)

.....
(Insured's Signature)

Date .....

STATEMENT OF ATTENDING PHYSICIAN OR SURGEON

DEFINITIONS OF DISABLEMENT

TOTAL DISABLEMENT implies immediate, continuous and absolute physical incapacity, as the result of accident , to attend to any portion of the business or occupation of the assured.

PARTIAL DISABLEMENT implies like continuous physical incapacity to perform one or more important daily dut or duties connected with the occupation of the insured.

1. Name of the Insured	
2. The date of first consultation by the insured	
3. Where did you first attend him? At his home, or at your Clinic or elsewhere?	
4. On what date did you last give him actual and necessary treatment for this injury?	..... 19 .....
5. Describe the exact nature location and extent of all injuries found by you on first examiniation. If injury involved eye, or limb, state whether right or left?	
6. What external or visible signs of violent injury did you find during your attendance?	
7. In your opinion, what was the cause of the unjury or conditions above described?	
8. Did the above injury necessitate any surgical treatment or surgical operation?	
9. How long was he totally disabled solely by this injury for which he was physically unable to perform any and every duty of his occupation?	
10. If not confined to house during any portion of the period of total disability, why was he unable to resume work, in whole or part?	
11. How long was he partially disabled, solely by this injury, os that he was physically unable to perform some important daily duties of his occupation? (Do not include any period of total disability in this)	From ..... 19 ..... To ..... 19 .....
12. Name the particular work he was unable to do during partial disability	
13. Has he previously suffered from the same or similar injury, or from injury to same part of body?	
14. Was he at the time of this accident or during this disability affected with any previous injury or any disease?	
15. Was he affected with any infirmity or physical impairement? If so, did the same contribut to cause the assident or to prolong ine disability? give particulars	
16. When and for what injuries or ailments have you previously treated him?	
17. How long have you been his family physician?	
18. Who had been his physician previsiously?	
19. Date on which total disability ended?	
20. Date on which partial disability ended?	

Dated _____

Signed _____

Attending Physician/Surgeon

Name (in block letters) _____

Qualifications _____ Year Graduated _____

Seal _____

Office Address _____