MetLife

ATTENDING PHYSICIAN STATEMENT

This statement to be furnished without expense to the Company.

Total Disability Benefits

1- Full name of Insured	**2- Where is Insured now located? (If an inmate of a hospital or other institution give name and address)**
3- How long have you been insured's medical advisor?	**4- When did Insured's health first become affected?**
5- Give Symptoms, Diagnosis and Prognosis of Disability.	
6- (a) Is Insured wholly disabled and prevented from engaging in any business or occupations whatsoever?	**6- (b) If be is, from what date, to your knowlege, has he been so prevented?** **(Month) (Day) (Year)**
7- (a) Date of your first visit or prescription in present affliction? **(Month) (Day) (Year)**	**7- (b) Date of your last visit or prescription in present affliction?** **(Month) (Day) (Year)**
9- When, in your opinion, may Insured be expected to do any Kind of work? **(Month) (Day) (Year)**	**8- Is Insured now confined to his bed or house? State Which ..... and from what date?** **(Month) (Day) (Year)**

10- Have you or any other physician or practitoner attended or treated Insured for any cause whatsoever prior to present affliction?

a- Name of disease or injuries?	**b- Datesnof attendance?** **From To**	**c- Name of physician or practitioner**	**d- Address**

11- Has Insured ever received treatment for spceifie disease? If so, give particulars.	
12- Has any member of Insured's family or any person in his immediate household ever been afflicated similarly? If so, Who?	
Additional Remarks:	**If heart is involved, what laboratory tests have been made?** **Pulse .....Irregular .....** **Blood Pressure S .....D .....**

Signature of Witness

Residence (No.) (Street) (City) (State)

Dated (Month) (Day) (Year)

Signature of Physician

Residence (No.) (Street) (City) (State)

Dated (Month) (Day) (Year)

STATEMENT NO.2