

**FAMILY LIFE INSURANCE COMPANY**

Administration Office: 10700 Northwest Freeway  
Houston, Texas 77092

Insured's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTENDING PHYSICIAN STATEMENT**

Dr. Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. Phone #: \_\_\_\_\_

Date: \_\_\_\_\_

Reference Number: \_\_\_\_\_

Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS/Clinic Number: \_\_\_\_\_

Code: 1-TAX ID#: \_\_\_\_\_

or

Code: 2-SS#: \_\_\_\_\_

In addition to this report, please send representative blood pressure reading, the dates taken, and any treatment prescribed.

In addition to this report, may we borrow EKGS, X-Rays which you may have? They will be returned promptly.

Amount Paid: \_\_\_\_\_

**Please complete this form in its entirety OR submit photocopies of Medical Records.**

On last examination: Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Date of Last Examination \_\_\_\_\_

Dates		DIAGNOSES	DURATION OF ILLNESS	ABNORMAL PHYSICAL FINDINGS	SYMPTOMS, B.P. READINGS AND TREATMENT OR
Month	Year				
OPERATION					

Dear Doctor:

In current negotiations the above applicant states that you have been the attending physician and authorizes you to furnish details of the clinical history. We appreciate your prompt cooperation in providing this report. A stamped, self-addressed, return envelope is enclosed for your convenience.

Thank You,  
Dr. Harry B. Kelso, M.D.  
Medical Consultant

Laboratory Findings: (Electrocardiograms, X-rays, Pathological report of any tissue removed, Blood, Urine, Etc.)

If you have ever diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) please give details.

Have any other Physicians or Surgeons been consulted? If so, who, when and for what reason?

Prognosis and present condition

Additional information

Date \_\_\_\_\_ Signature of Attending Physician \_\_\_\_\_ Degree \_\_\_\_\_