

Terminal Illness Medical Statement

To be completed by a registered medical practitioner. **The patient will incur any charge for this service.**

Mark boxes with where appropriate, otherwise use block letters. Leave a box between words.



Patient/claimant details

Title	Surname		
<input type="text"/>	<input type="text"/>		
Given names			
<input type="text"/>			
Address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Occupation/Profession	Date of birth		
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>		

Patient history

1 Are you the patient's usual doctor? Yes No

If 'YES', how long have you known the patient?

2 Please provide a diagnosis of the patient's present condition including symptoms:

(Please attach a copy of any medical reports/test results you have in your possession).

3 When did the patient first consult you for the present condition? / /

4 When was the present condition diagnosed? / /

5 When was the patient first diagnosed as having a life expectancy of less than twelve (12) months? / /

6 Based on medical opinion, what is your patient's life expectancy? Months

7 Please detail all past, present & future treatment for this condition.

Patient history (continued)

- 8 Please provide details of your patient's significant medical history. Does the patient have a prior medical history related to the present condition?

(Please include the year and diagnosis or provide a copy of your patient's clinical history).

- 9 Please provide details of other practitioners the patient has consulted for this condition: +

Name	Address and phone number	Qualifications	Date(s) consulted

Other information

Are you completing claim forms on behalf of the patient for any other company in respect of this condition? Yes No

If 'YES', please provide details:

Other comments: (please use this space if required)

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Your details (please print)

Title	Surname	
<input type="text"/>	<input type="text"/>	
Given names		
<input type="text"/>		
Address		
<input type="text"/>		
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone No.	Fax No.	
(<input type="text"/> <input type="text"/>) <input type="text"/>	(<input type="text"/> <input type="text"/>) <input type="text"/>	
Qualifications		
<input type="text"/>		
Signature of Medical Practitioner	Date	
<input type="text" value="x"/>	<input type="text"/>	



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