LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349 GADSDEN AL 35902

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

ALL QUESTIONS MUST BE ANSWERED BY THE ATTENDING PHYSICIAN

Policy Number(s): _____ Claim Number: _____

Patient's Name : _____

Patient's Address: _____

Date of Birth: _____ SSN: _____

Nature of Sickness: _____

The patient has been continuously disabled (unable to work) from: _____ through _____

If still disabled, when should the patient be able to return to work? _____

If the disability is due to pregnancy, what is the expected delivery date? _____

If the disability is due to pregnancy, what is the actual delivery date? _____

Remarks: _____

_____

_____ _____

Physician's Name (Please Print) Physician's Signature

Physician's Address: _____ Phone: _____

Date:_____