MetLife®

Doctor's Certificate – Disability due to Accident or sickness

Insured Name: _____ Insured ID no: _____

Date of Birth: _____

What are the conditions that lead to this patient's disability?

_____

_____

Please provide the start date for each of the above conditions

_____

_____

Please provide the cause leading to the disability

_____

_____

Does the accident or sickness prevent the insured to perform his work duties, or any other job for salary or profit?

_____

_____

Full time _____ Part-time _____

Is there any further treatment planned?

_____

_____

Do you consider the patient Permanently and Totally Disabled

a) for his own occupation
b) for any occupation?

To the best of my knowledge and belief above statements are true and accurate

Doctor's Name: _____ Date: _____

Signature and seal: _____