

**GROUP LIFE BENEFITS
 CERTIFICATE OF ATTENDING PHYSICIAN
 DISMEMBERMENT OR LOSS**

Patient's Name _____

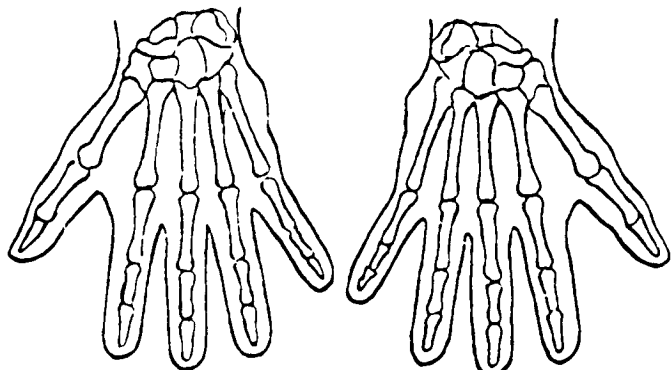
Patient's Address _____

Groups Policy No. _____

1. (a) When did the accident happen? Mo. _____ Day _____ 19 ____
 (b) Describe briefly, details of the accident. _____

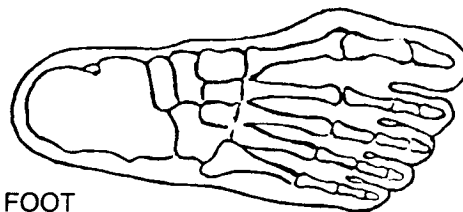
2. (a) Date of first attendance for present injury. Mo. _____ Day _____ 19 ____
 (b) Date of most recent treatment. Mo. _____ Day _____ 19 ____

3. (a) If the accident caused the loss of hand, foot fingers or toes, please indicate the point of amputation on the diagram below.
 (b) Date of amputation. Mo. _____ Day _____ 19 ____

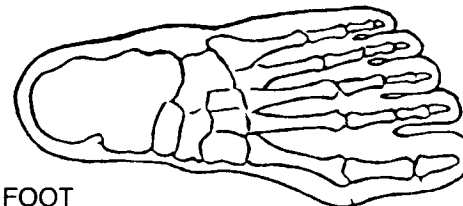


LEFT HAND

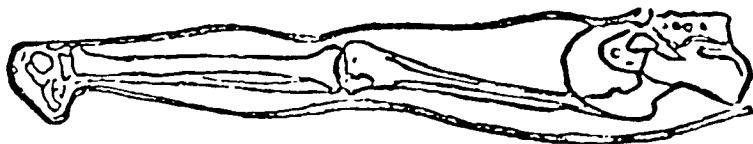
RIGHT HAND



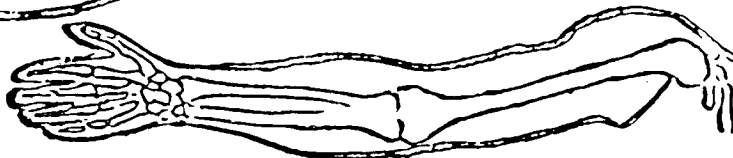
RIGHT FOOT



LEFT FOOT



INDICATE WHETHER RIGHT OR LEFT



4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which

Sight Hearing Speech

(b) Date on which loss occurred.

Mo. _____ Day _____ 19 _____

(c) Is there any possibility of improvement to the injured area?

Loss of Sight Only

(a) If known to you, please advise the vision in each eye prior to the accident.

(b) What percentage of vision, if any, now remains in the injured eye?

Loss of Hearing Only

(a) Is there any indication that hearing was abnormal prior to accident?

(b) Level of hearing at date of loss.

Loss of Speech Only

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

(b) Is insured's speech intelligible at the present time?

5. (a) If accident caused loss of use of leg, arm, or hand, please advise which.

(b) Is there any indication that the injured limb was unable to function normally prior to accident?

(c) Please indicate what functions, if any, the injured limb is able to perform.

6. (a) Was the injury described solely responsible for the loss?

(b) If not, give particulars of any contributing cause or causes

Date _____ Signed _____ M.D.

Address _____
Street City Province Postal Code