MEDICAL REPORT FOR ACCIDENTAL DISABILITY

Date: dd / mm / yy

Doctor's Name: _____

Address: _____

_____ _____ _____ _____

City State Country Postal Code

Ref: Patient Name: _____

Identification No: _____ Date of Birth: dd / mm / yy

Dear Dr. _____

Your patient has filed a claim for disability or injury benefits.

To evaluate this claim, we ask that you provide a report on the patient's condition and answer the following questions:

Definitive diagnosis: _____

_____

What is the cause of this pathology? _____

How did the injury or illness occur? _____

_____

If it was accidental, when did the accident occur? dd / mm / yy Hour: _____

Date you first saw the patient: dd / mm / yy

Reason for first medical attention: _____

_____

Indicated treatment: _____

_____

_____

Were they referred to another doctor(s) or specialist(s)? (explain):

How long do you estimate it will take for patient's full recovery?

Does the patient need any treatment to achieve full recovery? (explain)

If the injury is total and permanent, please explain in detail:

In your opinion, was the loss caused by a self-inflicted injury or act of self-destruction?

In your opinion, was the loss caused in any way by illness?

If yes, please indicate the dates on which you provided treatment for your illness:

Provide an account of the accident as you understand it happened:

Treatment dates for this accident:

Additional comments:

MEDICAL REPORT OF DISABILITY DUE TO ACCIDENT

INSURED INFORMATION

I certify that the above statements are complete and true to the best of my knowledge and belief.

Doctor's Name: _____

Specialty, degree or professional designation: _____

Registration or professional license number: _____

Phone(s): _____ Email: _____

Address: _____

_____ _____ _____ _____

City State Country Postal Code

Doctor's Signature: _____ Date: dd / mm / yy

Once completed and signed, the doctor must send this form directly to the company by email to claims@olelife.com or via WhatsApp to tel. +1-939-489-3160.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be charged with insurance fraud and subject to civil and criminal penalties.

Please include the following documents:

1. Copy of the insured's government issued ID
2. Copy of the doctor's professional license
3. Copy of the results of all medical examinations carried out since the beginning of this pathology
4. Copy of the medical record for each hospitalization, emergency room visit, outpatient visits, therapy sessions
5. Copy of the complaint, minutes or police report, if applicable
6. Medical bills related to the incident