



COMPLETE FOR DIAGNOSED DISEASE

1. Date you were first consulted for the symptoms of his condition:

Month : _____ Day : _____ Year : _____

2. Date patient had previous medical attention for this condition :

Month : _____ Day : _____ Year : _____

Physician _____

Address : Street _____ City _____

3. Dates confined to Hospital :

From : _____ To : _____

From : _____ To : _____

4. Hospital Name _____

Address _____

5. Has disease been caused by : (Give Details)

a. Acquired Immune Deficiency Disease Virus (HIV) , or is it an AIDS related complex of infection by HIV Virus?

b. Misuse of Drugs or Alcohol ?

Name of Attending Physician _____

Hospital or clinic address _____

Signature _____ Date : _____

**RECOVERY BENEFIT PLAN /
 CRITICAL ILLNESS FORM**

POLICY NO. _____

PART A - INSURED'S STATEMENT

Name of Insured _____

Insured's Address: _____

Street _____ P.O.Box _____

City _____ Country _____

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1. Nature of Disease _____

2. Date of First Consultation _____

3. Date of Diagnosis of Disease _____

4. Has disease been caused by:

a. Acquired Immune Deficiency (AIDS)? _____

b. Misuse of drugs or alcohol ? _____

5. Cardiac Bypass Surgery (if applicable)

a. Date of Surgery _____

b. No. of Coronary Arteries involved _____

6. a. Name of Treating Physician _____

b. Physician's address _____

AUTHORIZATION

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of their records) regarding myself, my medical history in general and this claim in particular to ALICO, AMERICAN LIFE INSURANCE COMPANY.

A photocopy of this authorization shall be considered as original.

Signature of Insured _____ Date _____

PART B - PHYSICIAN'S STATEMENT

Name of Patient _____ Date of Birth _____

Height _____ Weight _____

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1- COMPLETE FOR MYOCARDIAL INFARCTION

a. Final diagnosis _____

b. Date of Diagnosis _____

c. Was there history of Chest Pain ? Yes _____ No _____
If yes, give details.

d. Did EKG reveal new Electrocardiographic changes ? Yes _____ No _____
If yes, give details.

e. Was there elevation of Cardiac Enzymes ? Yes _____ No _____
(Company requires all laboratory test, EKG and X-RAYS done)

2- COMPLETE FOR CORONARY ARTERY DISEASE REQUIRING SURGERY

a. Date of Diagnosis _____

b. Nature of Surgery _____

c. Date of Surgery _____

d. No. of Coronary Arteries involved _____
(Company requires all laboratory Test, EKGs and Catheterization Film & Diagram)

3- COMPLETE FOR CEREBRAL STROKE

a. Final Diagnosis _____

b. Date of Diagnosis _____

c. Did EEG reveal permanent neurological deficit? _____
(Company requires all laboratory Test, EEGs and Neurologist Opinion Confirming diagnosis)

4 - COMPLETE FOR CANCER

a. Detailed final diagnosis including location _____

b. Date of Diagnosis _____

c. Medical History _____

(Company requires all laboratory and Tissue Biopsy Pathology Tests)

5 - COMPLETE FOR CHRONIC, IRREVERSIBLE RENAL FAILURE

a. Detailed diagnosis _____

b. Date of Diagnosis _____

c. Medical History _____

d. Nature of Treatment _____

(Company requires all laboratory Tests)

6 - COMPLETE FOR BLINDNESS CAUSED BY SICKNESS

a. Nature of Sickness _____

b. Is blindness total, permanent and irrevocable ? Yes _____ No _____

c. Date of Diagnosis _____

d. Medical History _____