



10319 Dawson's Creek Blvd., Ste. C
Fort Wayne, IN 46825

Ph: 260.492.7451
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Attending Physician Statement
(please print in ink or type)

Patient Name: _____ Date of Birth: _____

Dear Doctor:

My employer has applied for group health coverage administered by CORE *Benefits, Inc.* Additional information is required for underwriting purposes. CORE *Benefits, Inc.* will not be responsible for any cost incurred for the preparation of this form. Please answer the questions below. This form must be returned to CORE *Benefits, Inc.* before coverage can be approved. Thank you for your assistance.

Patient's Signature (not applicable if release is attached) Date

1. Condition Diagnosed: _____

2. Date of Onset: _____ Date of first consultation (please include Ht., Wt., & B.P.): _____

3. Recommended Treatment (please include any medication prescribed): _____

4. Was Individual Hospitalized? No Yes If yes, give date(s): _____

5. Was surgery performed? No Yes If yes, give date(s) and details: _____

6. Date(s) of follow-up treatment/consultation with details of prognosis each treatment/consultation: _____

7. Have any other physicians/surgeons been consulted? No Yes If yes, please give name, date, and nature or disorder: _____

8. Current treatment (please include medication, if any, Ht., Wt., & B.P.): _____

9. Present Condition and Prognosis: _____

10. Any other pertinent health information in your files (please attach additional documents if necessary): _____

Signature of Attending Physician Degree Date

Name of Attending Physician Telephone Number

IMPORTANT: Unanswered questions can result in the application's being returned without review. Your cooperation in completing this form in its entirety will be appreciated. Information furnished will be held confidential.