Ind. No. 21 10M-3-13

PRELIMINARY NOTICE OF

ILLNESS.

TO BE FILLED OUT BY THE ASSURED.

NOTE.—Immediately after beginning of illness this blank must be executed by claimant and physician and forwarded at once to the Company at New York, or to the duly authorized agent for the locality in which this policy is issued. Every question must be answered fully.

I .....age.....weight.....height.....**Policy Number**.....
insured in **THE FRANKFORT GENERAL INSURANCE CO.,** of Frankfort-on-the-Main, Germany, was taken ill

on.....19.....at ....o'clock....M. and quit work on.....19.....at.....o'clock.....M.

and for the purpose of applying for such benefits as I may be entitled to, make answer to the following questions, which answers I hereby warrant to be absolutely true and correct, without evasion or reservation, and I AM WILLING TO TESTIFY UNDER OATH thereto if required.

1 **When did physician first attend you?**.....19.....hour.....M. **Where**.....
(At your home, his office, or elsewhere.)

2 When did you make your last three premium payments?.....19..

3 To whom did you pay them?.....

4 **What was your occupation when taken ill?**.....
(Describe your usual duties.)

5 **Name the disease?**.....
(Describe symptoms fully. Name part of body affected.)

.....

6 **Are you able to leave the house?**.....**Are you confined to bed continuously?**.....

7 **When do you expect to be able to leave the house?**.....19.....

8 How long since you were afflicted with same disease before?.....1.....

9 Have you had any medical attendance during past five years?.....
(Name diseases and number of times ill.)

.....

10 Do you work on a fixed salary, or commission, or by piece work?.....What are your average earnings therefrom?

$.....per.....Did you have steady employment when taken ill?.....

11 To what extent do you use narcotics, liquors, or drugs?.....

12 Are you insured against illness in any other organization?.....
(Name the organizations and the amount carried in each.)

13 Have you made claim on this or any other organization before?.....
(Name organizations and the amount each paid you and dates of payment.)

14 Give physician's name..... Address.....

15 Give employer's name..... Address.....

Dated.....19.... **Claimant sign here**.....

Town.....**Street**.....**County of**.....**State of**.....
(Where you can be found while disabled.)

PHYSICIAN'S

PRELIMINARY REPORT OF

ILLNESS

Dated.....*19*....

Report of examination of Mr.....

1 (a) Do you know that he is the person described on reverse hereof? Answer.....(b) How long have you known him?

Ans.....(c) Are you his regular or family physician? Ans.....(d) Are you related to him? Ans.....

2 **When and where did you first examine claimant?**.....19.....hour.....M., at..... .....
(Your office, his home, or elsewhere)

3 **Name the disease** causing the disability..... .....Has he any others?.....
(If so, what?)

4 **State precisely the nature of the illness** .....
(Give complete diagnosis of the case.)

....

5 Describe the symptoms that lead you to diagnose the disease as above..... .....

....

6 Is the disease acute?.....Chronic?.....Venereal?.....Give temperature..... Pulse.....Respiration.....

7 Did any complications arise?.....Did you perform any operation?..... .....

8 **Does the illness necessarily confine him strictly in the house?**.....**in bed?**..... .....

9 If so, how soon in your opinion will he be able to leave the house counting from the first day of continuous confinement?.....**days.**

10 **How many times and on what dates** have you visited at his home?.....**Times.** **Dates**..... .....

....

11 **How many times and on what dates** has he been to your office for treatment.....**Times.** **Dates**.....

....

12 Has the claimant in your knowledge or opinion suffered from the same or any similar disease prior to this attack?.....

13 Is the above named illness the sole cause of his confinement?.....Is he improving?.... .....

14 Have you reported the claimant for any other company or organization?.....

15 Does the claimant use intoxicating liquors, drugs, or narcotics to excess, or to a degree to impair his health?.....

16 Has the claimant any chronic or constitutional disease or infirmity or any physical defect or deformity? If so, what?.. .....

....

I Hereby Certify, That the foregoing answers and statements are absolutely true and correct, **without evasion or reservation,** and are made subsequent to a thorough examination of the claimant by me.

.....**Attending Physician.**

Graduate of..... **Street Address**.....