Amalgamated Life Insurance Company
Policy Services Department
333 Westchester Avenue
White Plains, NY 10604
1-914-367-5000

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Name of patient _____ Age _____
2. (a) Date first consulted on account of the injury described _____ 20 _____
   (b) Date of last treatment _____ 20 _____
3. Describe the exact nature, location and extent of all injuries sustained _____

TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS

4. (a) Which limbs were severed or amputated?

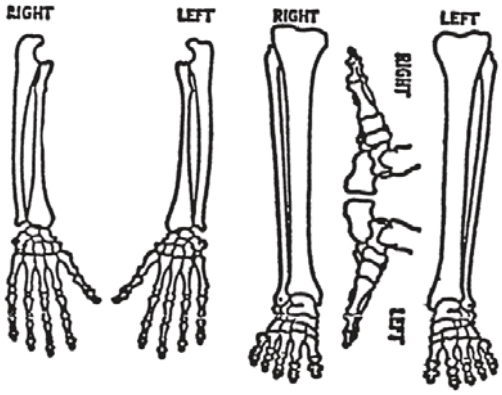
   (b) State the dates on which the severances or amputations occurred.

   (c) State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

5. State the causes of the amputations.

6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated or examined.

7. Please give the names of such other physicians as have attended this patient, and the dates of their first and last treatments as reported to you.



TO BE COMPLETED ONLY FOR LOSS OF VISION

4. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each.

   (a) Date _____

   (b) Snellen Notations

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

5. Give the date and vision found on last eye examination.

   (a) Date _____

   (b) Snellen Notations

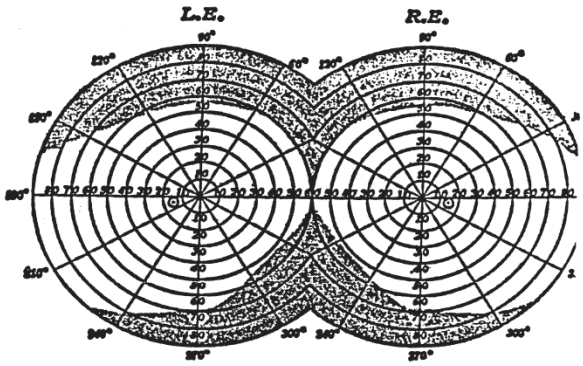
	Uncorrected	Corrected
O.D.v.		
O.S.v.		

6. State the causes of loss of vision.

7. Indicate whether recovery of useful vision is possible by operation or treatment.

   O.D. ❑ Operation ❑ Treatment
   O.S. ❑ Operation ❑ Treatment

7. (a) If fields of vision are contarcted, show contraction on chart below.



8. (a) Was the injury described solely responsible for the loss? _____
   (b) If not, give the particulars of any contributing cause or causes. _____

Signed _____
Address _____
_____
Phone No. _____

Date _____ 20 _____