To: Tokio Marine & Nichido Life Insurance Co., Ltd

Attending Physicians Statement

1.Name of patient	Sex	Date of birth (dd/mm/yyyy)
	☐M ☐F	/ /

2. Diagnosis

(i)Inception date / / (dd/mm/yyyy) ☐doctor's presumption ☐patient's claim	(ii)Illness/injury for admission/operation
(iii)Cause of (ii)	**(iv)Complications/Additional diagnoses**

3.First medical consultation	4.Period of treatment
/ / (dd/mm/yyyy)	From / / (dd/mm/yyyy) To / / (dd/mm/yyyy)

5.Period of hospitalization

From / / (dd/mm/yyyy) To (*1) / / (dd/mm/yyyy) At the date of (*1) , patient: ☐still in hospital ☐discharged ☐transfered to other hospital ☐other( )

From / / (dd/mm/yyyy) To (*2) / / (dd/mm/yyyy) At the date of (*2) , patient: ☐still in hospital ☐discharged ☐transfered to other hospital ☐other( )

6.Previous medical facility/physician (if any)

Name of the medical facility	Name of the physician
Address	Date of first visit / / (dd/mm/yyyy)

7. Operation(*Operation includes chest tube drainage, intraperitoneal drainage, stent change and port implantation.)
Type of operation: Select from the list below and write numbers (1-12) in the item of "Type of operation"

1 craniotomy
2 burr hole opening
3 thoracotomy
4 thoracoscopy
5 laparotomy
6 laparoscopy
7 transurethral
8 transvaginal
9 endoscopic surgery or transluminal intervention
10 laser surgery
11 shock wave lithotripsy
12 others

1

Type of operation (1-12)	Name of operation	Date (dd/mm/yyyy)

Side	Bone/joint surgery	Manipulation of Muscle/tendon/ligament (ex.dissection, ligation)
☐ Left ☐Right ☐Not applicable	☐open ☐closed ☐Not applicable	☐Yes ☐No ☐Not applicable

In case of finger (hand/foot) surgery , surgical area	In case of skin graft/skin flap, surgical area is
☐includes metacarpophalangeal joint ☐does not include metacarpophalangeal joint	☐equal to/more than 25cm^2 ☐less than 25cm^2

2

Type of operation (1-12)	Name of operation	Date (dd/mm/yyyy)

Side	Bone/joint surgery	Manipulation of Muscle/tendon/ligament (ex.dissection, ligation)
☐ Left ☐Right ☐Not applicable	☐open ☐closed ☐Not applicable	☐Yes ☐No ☐Not applicable

In case of finger (hand/foot) surgery , surgical area	In case of skin graft/skin flap, surgical area is
☐includes metacarpophalangeal joint ☐does not include metacarpophalangeal joint	☐equal to/more than 25cm^2 ☐less than 25cm^2

8.Radiation therapy and thermotherapy	Period (dd/mm/yyyy)	At the date of(*3)	place
☐Thermotherapy ☐Brachytherapy ☐Others	From / / To / /	☐under radiation therapy ☐radiation completed	doze Gy

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All copies require your signatures.
If you need more space for description, please use the back of the paper and add your signature next to the writing.

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9.Period of occupational disability	From (dd/mm/yyyy) / / To (dd/mm/yyyy) / /
10.In case of acute myocardial infarction	Whether limitation of work (excluding the one such as housework / desk work) has continued more than 60 days from the first visit. ☐Yes ☐No
11. In case of stroke	Whether limitation of work (excluding the one such as house work / desk work) has continued more than 60 days from the first visit. ☐Yes ☐No
	Whether sequelae of central nervous system has continued more than 60 days from the first visit. ☐Yes ☐No If Yes, please describe details:

12. In case of neoplasm

(i)Final diagnosis / / (dd/mm/yyyy)

(ii)Examination for Diagnosis

Examination	Date of final result	Result
Histology	/ / (dd/mm/yyyy)	
Cytology	/ / (dd/mm/yyyy)	
Other examination	/ / (dd/mm/yyyy)	

TNM classification, Invasion depth, Condition

	In case of colon cancer,	Present condition
T( ) N( ) M( ) Stage( )	☐m ☐sm or deeper	☐cured ☐remission ☐therapy continued

(iii)Has this patient ever diagnosed malignant or non-invasive carcinoma (including carcinoma in situ)
☐No
☐Yes
Diagnosis: Date of Diagnosis / / (dd/ mm/ yyyy)

(iv)Antineoplastic	Name of Antineoplastic
☐not administered ☐will be administered ☐being administered	Date of administration (mm/yyyy) / , / , / , / , / , / , / , /

13.Outpatient visit dates for treatment

Month/Year	Please circle the dates.
/	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
/	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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/	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

I hereby certify that the above-stated facts are true and correct.

Country: Address of hospital/clinic: Name of hospital/clinic: Department: Telephone number:	Date of Certification / / (dd/mm/yyyy)
Name of Doctor	Signature