To ORIX Life Insurance Corporation
English Only; Please type or write in block letters.

B6 ATTENDING PHYSICIAN'S STATEMENT (PROOF OF HOSPITALIZATION/OPERATION etc)

ORIX Life Insurance Corporation

1. Name of patient

	Sex	☐ M. ☐ F.	Date of birth	Day / Month / Year / /

2. Name of Disease and/or Injury

(a)Name of Disease/ Injury for hospitalization (Operation)		Onset Date of Disease/Injury Day / Month / Year / /
(b)Cause of the above (a)		Onset Date of Disease/Injury Day / Month / Year / /
(c)Name of Disease /Injury for hospitalization(including complications)except "(a)"&"(b)"		Onset Date of Disease/Injury Day / Month / Year / /
(d)Period of Medical treatment	Day / Month / Year / / (Initial Consultation) ~	Day / Month / Year / / (Final Consultation)
Date of notification	☐ Yes. → Patient was notified on (Day / Month / Year) / / that the name of the disease was ( ) ☐ No.	

3. Past History and Chronic Disease

☐ Yes. → ☐ No.	Name of Disease,Period of Treatment etc.	Name/Address of Medical Institution

4. Hospitalization

1st Hospitalization	Day / Month / Year / / ~	Day / Month / Year / /	(Inpatient / Discharged)
2nd Hospitalization	Day / Month / Year / / ~	Day / Month / Year / /	(Inpatient / Discharged)
After 3rd Hospitalization			

5. Operation

	Name of Operation	Date of Operation	Type of Operation	Details of Operation
1st Operation		Day / Month / Year / /	(①~⑫) ※Please choice[ ]	(①~⑩) ※Please choice[ ]
2nd Operation		Day / Month / Year / /	(①~⑫) ※Please choice[ ]	(①~⑩) ※Please choice[ ]

①Craniotomy ②Cephalocentesis ③Thoracotomy ④Thoracoscopic ⑤Laparotomy ⑥Laparoscopic
⑦Fiberscope or Catheter ⑧Percutaneous ⑨Transurethral ⑩Transvaginal ⑪Ophthalmic Laser
⑫Others( )

- Surgery of Bone,Joint,Muscle,Tendon and Ligament [①Open, ②Closed]
- Manipulation of muscle, tendon and ligament [③Yes, ④No]
- In case of Extremity,operative site is MP Joint and/or proximal [⑤Yes, ⑥No]
- In case of Dermatoplasty(Skin Flap), grafts equal to [⑦25 ㎝ or larger, ⑧smaller than 25 ㎝]
- As a Fiberscope or Catheter, the site of surgery, treatment [⑨Limb, ⑩other than Limb(Center)]

6. Radiotherapy

Region	Total dose	Period	
	( )Gy	Day / Month / Year / / ~	Day / Month / Year / /

7. In case of Acute Myocardial Infarction

Can work for more than 60 days after initial consultation and He/She is able to do light labour. Any restrictions :	[Yes, No]

8. In case of Stroke

Do such objective, neurological sequelae as dysphasia, ataxia and paralysis still exist 60 days after the initial consultation?	[Yes, No]	If yes, please detail the sequelae

9. In case of Malignant Neoplasm or Intraepithelial Neoplasm

Date of definite diagnosis	Day / Month / Year / /	(P)TNM classification	(P)T( ) N( ) M( )	Type	[Primary lesion/ Recurrence/Metastasis]	[Skin cancer/Carcinoma in situ/ Noninfiltrating carcinoma/Others]

Inspections and inspection results executed until the diagnosis

	Inspection Date	Result Date	Result summary
Histopathological examination	Day / Month / Year / /	Day / Month / Year / /	(The Name of Histopathological diagnosis)
Cytological examination	Day / Month / Year / /	Day / Month / Year / /	
Endoscopy	Day / Month / Year / /	Day / Month / Year / /	
CT-MRI	Day / Month / Year / /	Day / Month / Year / /	
Others( )	Day / Month / Year / /	Day / Month / Year / /	

In case of dysplasia of the uterine cervix, please check one of	In case of dysplasia of uterine cervix or borderline malignancy(Gastrointestinal Stromal Tumor)
CIN's Ⅰ Ⅱ Ⅲ	ICD-O[ ]

10. In case of treatment received as Outpatient for Cancer treatment

①Please circle the applicable day(s).Treatment Received as Outpatient for a) to d)
a)Operation b)Radiotherapy c)Hyperthermia d)Chemotnerapy

Month / Year	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
Month / Year	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
Month / Year	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
Month / Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
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Month / Year	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
Month / Year	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

②Please circle the applicable day(s).Treatment Received as Outpatient for Cancer treatment except "①"

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

These statements are true and complete to the best of my knowledge and belief.

Name of hospital

Address of hospital

Signature of doctor

Date Day / Month / Year
/ /

Country