RELIANCE
Life Insurance

Claim Form B - Medical Attendant Certificate by the last treating doctor

(All answers to be in Block Letters – No Dots and Dashes)

In connection with Claim under Policy No:

1. Name of the Life Assured: _____

2. Age of the life assured: _____

3. Address of the Life Assured: _____

4. Name and address of the Hospital/ Clinic: _____

5. Are you satisfied regarding the identity of the Life assured whose name and address are furnished above? **YES / NO**

6. What was the diagnosis? _____

7. Date when diagnosed first: _____

8. Direct Cause/s of Illness: _____

9. When did he/she first complain of Illness? _____

10. What was the nature of complaint? _____

11. What was the history reported to you at the time of consultation? _____

12. By whom was it reported? (Mention Name & Relationship to the Patient): _____

13. How long has he/she been suffering from the illness? _____

14. Were any tests conducted? If so, mention the tests and findings of the tests: _____

15. Date and hour of Admission: _____ Admission No. _____

16. What was the condition of the patient at the time of Discharge? _____

Enclosures:

1. Attested copy of Investigation reports / hospital reports (case summary)
2. Discharge Summary
3. Other if any……

The above particulars are furnished on the basis of the records maintained by the Hospital/Clinic.

Date: _____

Place: _____

Signature of the attending Doctor

Name of the Doctor: _____

Designation: _____ Hospital / Clinic Seal