



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: \_\_\_\_\_

Name of the Doctor: \_\_\_\_\_

Designation: \_\_\_\_\_ Hospital / Clinic Seal

Signature of the attending Doctor

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