RELIANCE NIPPON LIFE INSURANCE

Policy No. | | | | | | | | |
Date | D | D | M | M | Y | Y | Y | Y |

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

Name of the Life Assured FIRST LAST

Age of the Life Assured

Correspondence Address/ Usual place of residence FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE MOBILE

Name and Address of the Hospital/Clinic

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pincode

STD ISD Code LANDLINE EMAIL ADDRESS

Are you satisfied regarding the identity of the Life Assured whose name and address are furnished above?

☐ Yes ☐ No

What was the diagnosis?

Date when diagnosed first D D M M Y Y Y Y

Direct Cause(s) of Illness

When did he/she first complain of Illness? D D M M Y Y Y Y

What was the nature of complaint?

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

By whom was it reported? (Mention Name & Relationship to the Patient)

How long has he/she been suffering from the illness? ☐☐ Years ☐☐ Months ☐☐ Days

Were any tests conducted? If so, mention the tests and findings of the tests

Date and Time of Admission D D M M Y Y Y Y TIME Admission No.

What was the condition of the patient at the time of Discharge?

Enclosures

1. Attested copy of investigation reports/hospital reports (case summary) ☐ Yes ☐ No

2. Discharge Summary ☐ Yes ☐ No

3. Other, if any ☐ Yes ☐ No If yes, please specify

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

Date D D M M Y Y Y Y

Place

Name of the Doctor

Designation

Hospital/Clinic Seal

Signature of the Attending Doctor

CIN: U66010MH2001PLC167089

Claims/FormB/Ver 1.4/Mar2018