TREATING DOCTOR'S CERTIFICATE

(To be completed by the doctor who treated / attended the Life Insured)

No fees, commission or changes of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Name of the Lite Insured (*Patient")	Age at event

1. Please provide details of the first consultation by the Patient. Please enclose copies of all relevant medical reports.

(a) Date of consuitation:----------

(b) Symptoms:----------

(c) Duration of the symptoms/illness:----------

(d) Diagnosis arrived at:----------

(d) History provided by:---------- History recorded by----------

(f) Treatment given:----------

2. Please provide the Risk Factors (Personal) of Lie Patient

S. No.	Risk Factor	Status	Status	Duration
1	Diabetes	Y	N	
2	Hypertension	Y	N	
3	Angina / IHD / CAD	Y	N	
4	Cancer	Y	N	
5	Lung Disease PI specify.....	Y	N	
6	Any other, PI specify.....	Y	N	

3. Detalls of Hospitalization:

Name of the Hospital ----------

Date of admission---------- Date of discharge/ death----------

Diagnosis arrived at.----------

Immediate cause of death,----------

Secondary cause of death ----------

4. Has the patient any history of previous hospitalizations / surgerles. (If 'YES' kindly provide us the details)

S. No.	Reason / Surgery	Dates
1		
2		
3		

5. Drugs History (If YES' please mention generic name)

S. No.	Drugs Name & Dose	Duration
1		
2		
3		
4		
5		

6. Has the patient previously suffered from any similar illness? If 'Yes', please provide details.
(i) Name of disease:---------- (ii) Date of diagnosis:----------

7. Was there any other antecedent or contributory disease / disorder or ailment? If Yes', please provide nature and duration of the disease / disorder or ailment ----------

8. Is the Patient suffering from any other major, chronic or congenital disease? If yes, please provide details.
(i) Name of disease:---------- (ii) Date of diagnosis:----------

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9. Were the Patient's habits sober? If 'No', please provide details below:
(a) Alcohol: (i) Nature of substance consumed----------
(ii) Duration and quantity of consumption.----------
(b) Smoking / use of tobacco: (i) Nature of tobacco abuse----------
(ii)Duration and quantity of consumption,----------

10. Had the Patient availed of treatment from any other doctor / hospital prior to his admission in the hospital? If so, please furnish details below:
(a) Name and address of the doctor / hospital:----------
(b) Nature of illness:----------

11. Was the patient referred to any other Doctor for current / associated ailment? If so, please furnish details below:
(a) Name and address of the doctor/ hospital:----------

Date of referral:---------- History reported:

I / we hereby state that I / we have treated the Patient in connection with the above condition and that the facts as given above are based on the records of the hospital and are correct to the best of my / our knowledge.

Signature & Seal of the Doctor / Hospital :

Name of Doctor	Registration No.	
Qualification	Specialization (if any)	
Address		
Contact Number(s) Pi mention	Date	
E-Mail id of doctor/ hospital		

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