AVIVA
Life Insurance

# Last Medical Attendant's Report

| **Policy No -** | | **Date** | |
|---|---|---|---|

| **(1). Personal Details of the Life Assured:** |
|---|
| Name: |
| Address: |
| Apparent Age at the Time of Death: |

| **(2). Details Relating to Death** | |
|---|---|
| Date of Admission | |
| Date & Time of Death | |
| Place of Death (Address) | |
| Was Post-Mortem Performed on the life Assured? Yes/No | If yes,Name and Address of the Hospital Where the Post Mortem was performed: |
| Primary Cause of Death | |
| Secondary Cause of Death | |
| Symtoms prior to Death | |
| Symptoms Duration prior to Death: | |
| **Were these causes ascertained by examination after death or from the symptoms and appearances during Life?** | |

| **(3). Details of History Reported at the Time of Death** | | |
|---|---|---|
| Name, Address & Telephone no. of referring Doctor: | | |
| Date of First Consultation: | | |
| Date of First Admision in Hospital: | | |
| Histroy recorded at the time of Consultion/admission: | | |
| Name of Illness/Complaints | | Since when? (Date & Time) |
| | | |
| | | |
| | | |
| | | |
| **History was given By** | **Life Assured/Others**. If Others: Name: | |
| | Age: | Sex: |
| | Relationship with the Assured: | |
| **History was Recorded By** | Name: | |
| | Designation: | |

## (4). Investigations Conducted

**Was any Investigation conducted on the life Assured:**

| Type of Investigation Conducted | Results/Readings |
|---|---|
| | |
| | |
| | |

Diagnosis made after investigation- Name of **Illness/Diseases**:

Name, qualifications & Address of the Doctor by who the above Diagnosis were made:

Treatments Given:

Name,Qualifiactions, Address,telephone no. - of Life Assured usual medical consultant/Family Doctor:

**(5). Had the Life Assured been ever admitted on earlier Occasion to this hospital or had the medical**

| As In-Pateint | As Out-Patinet | Dates | | Complaints / Symptoms | Treatment Given | Name,Adress & Telephone of the Treating Docotor |
|---|---|---|---|---|---|---|
| | | From | To | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**(6). Habits of the Life Assured:**

a) Were the Life Assured 's habits Sober & Temperate? YES / NO

b) Did he have any additction such as Smokin, Drinking etc.? YES/ NO.

If Yes, Pls befief about the quantity of the consumption:

c) Have you any reason to suppose or to supect that the disease was in this case caused or aggravated by

**(7a.)** When & for which other disease/ailment/illness did you treat the life Assured in the last 3 yeas before this?

**(7b)**. Any other information, which you consider would be useful for processing the claim under the Policy.

Singnature of the Medical Attendent | Date:

Name & Registeratio No.

Stamp & Address | Place: