AVIVA
Life Insurance

Last Medical Attendant's Report

PERSONAL DETAILS OF THE LIFE INSURED

Policy Number

Name of Life Assured Apparent Age at the Time of Death

Was the deceased referred by another Doctor or Hospital? If yes, please give details

Name of Doctor/Hospital ______ Address of Doctor/Hospital ______

DETAILS RELATING TO DEATH

Date of Death D D M M Y Y Y Y Time of Death H H M M

Date of Admission D D M M Y Y Y Y Date of Discharge/Death D D M M Y Y Y Y

Primary cause of Death ______

Secondary cause of Death ______

Symptoms prior to Death ______ Duration of Symptoms prior to Death ______

What were the Life Assured's presenting complaints? ______

Were these causes ascertained by examination after Death or from the symptoms and appearances during Life? ______

HISTORY RECORDED AT THE TIME OF CONSULTATION

Were you the Life Assured's family Doctor? If yes, please give details on how long you have known the deceased ______

Date of First Consultation D D M M Y Y Y Y Date of First Admission in Hospital D D M M Y Y Y Y

Details of Illness	
Name of Illnesses/Complaints	**Since when? (Date and Time)**

INVESTIGATIONS CONDUCTED

Was any Investigation conducted on the Life Assured? ☐ Yes ☐ No

If yes, please give the below details

Type of Investigation Conducted	Results/Readings

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Diagnosis made after investigation - Name of Illnesses/Diseases ____________________

____

Name, Qualifications & Address of the Doctor who conducted the diagnosis ____________________

____

Treatments given ____________________

Had the Life Assured been ever admitted on earlier occasion to this hospital or had the Medical Attendant treated him/her earlier? If yes, please fill the following details

As In-Patient	As Out-Patient	Dates		Complaints/ Symptoms	Treatment Given	Name, Address & Telephone No. of the Treating Doctor
		From	To			

HABITS OF THE LIFE ASSURED

Were the Life Assured's habits sober & temperate? ☐ Yes ☐ No

Did he have any addiction such as Smoking, Drinking etc.? ☐ Yes ☐ No

If yes, kindly state the quantity of the consumption ____________________

Have you any reason to suppose or to suspect that the disease was in this case caused or aggravated by intemperate habits? ____________________

____

When & for which other Diseases/Ailments/Illnesses did you treat the Life Assured in the last 3 years? ____________________

____

Any other information, which you consider would be useful for processing the Death Claim ____________________

____

Name and Registration No. ____________________ Date D D M M Y Y Y Y

Address ____________________

____

Signature of Medical Attendant

Hospital Stamp

Aviva Life Insurance Company India Limited
401-A, 4th Floor, Block A, DLF Cyber Park, Sector-20, NH-8, Gurugram, Haryana-122 016
www.avivaindia.com

Customer Service Helpline Number
1800-103-77-66 (Toll Free)
0124-270-9046

Email
claims@avivaindia.com