Medical Attendant's Report

Policy No-	Date-

I. General Information

1 a) Name of Life Assured…… b)……

2. Were you the Life Assured's usual Doctor? If "yes", Please give details how long have you known the deceased……

3. Date of Death…… 4. Immediate cause of Death……..

5. Underlying cause of Death…… 6. Duration of Ailment……..

7. Was the deceased referred to you by another Doctor or Hospital? If "yes", please give details:

Name of Doctor/Hospital…… Address of Doctor/Hospital……..

II. Information About the illness and accident:

1. Details of Illness/Accident……

2. Date of First Consultation……

3. Date of Diagnosis……

4. What were the Life Assureds' presenting complaints……

5. History of Present Illness …… 6. Any other past medical illness……

7. Did the deceased suffer from any other ailment other than the ailment that eventually led to death?

Yes ☐ No ☐

If yes, give brief particular of it with duration and treatment rendered……

III. Other Information

1. Name and address of Hospital were Life assured was admitted……

2. Date of Admission…… 3. Date of Discharge/Death……

4. Admission no./C.R. No./IP No…… 5. Details of treatment rendered……..

IV. 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:_____

_____

V. 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			

VII. 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	

When & for which other disease/ailment/illness did you treat the life Assured in the last 3 years before this?_____

Any other information, which you consider would be useful for processing the claim under the Policy._____

Signature of the Medical Attendant **Date:**
Name & Registration No.
Stamp & Address **Place:**