

Claim Form B - Medical Attendant Certificate

(To be filled in by Last Treating Doctor)

Policy No.

Date

(All answers to be in Block Letters No Dots and Dashes)

Name of the Life Assured

Age of the Life Assured

Correspondence Address/ Usual place of residence

STD ISD Code

Name and Address of the Hospital/Clinic

STD ISD Code

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

Direct Cause(s) of Illness

When did he/she first complain of Illness?

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

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

Place

Name of the Doctor

Designation

Hospital/Clinic Seal

Signature of the Attending Doctor

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