IndusInd Nippon Life

Claim Form B - Medical Attendant Certificate

(To be filled in by Last Treating Doctor)

Policy No.

Date D D M M Y Y Y Y

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

Name of the Life Assured FIRST MIDDLE LAST

Age of the Life Assured

Correspondence Address/ Usual place of residence FLAT NO. BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE MOBILE

Name and Address of the Hospital/Clinic

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

STD ISD Code LANDLINE 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 D D M M Y Y Y Y

Direct Cause(s) of Illness

When did he/she first complain of Illness? D D M M Y Y Y Y

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 D D M M Y Y Y Y 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 D D M M Y Y Y Y

Place FIRST MIDDLE LAST

Name of the Doctor

Designation

Hospital/Clinic Seal

Signature of the Attending Doctor

CIN: U66010MH2001PLC167089

Mktg/BPD/Claims/FormB/Ver 1/Nov 2025