

Without prejudice

**Important points:**

- This form needs to be completed by the Hospital Authorities where the Life Assured was either admitted or treated
- If the Life Assured has been admitted in two different hospitals the form is to be filled up per hospital
- Medical records such as Death/Discharge Summary, Inpatient / Outpatient records, Operation notes, Progress records wherever applicable to be provided along with this form

Policy No.: \_\_\_\_\_ Date:

Name of the Patient: \_\_\_\_\_ Inpatient No./MRD No.: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_ years

**Details of the hospital**

1. Indoor patient no.: _____	
2. Date of Admission: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date of discharge: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Time ____ : ____ (In 24 Hrs format)	Time ____ : ____ (In 24 Hrs format)
3. Was the patient admitted to ICU?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please provide us with the following) Days of admission in ICU: _____ (No. of days) From <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> to <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
4. Was the patient referred by any doctor/hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please provide us with the following) Name & Address: _____ _____ Tel. No.: _____

**Details of the illness suffered**

1. Definitive discharge diagnosis: _____	Date of diagnosis: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
2. Symptoms insured presented with, related to current illness (please specify separately if multiple symptoms)	1) _____ 2) _____ 3) _____
3. Duration of the said symptoms (please specify separately if multiple symptoms)	1) _____ 2) _____ 3) _____
4. Investigations done and their findings:	
5. Treatment given during the course of hospitalization:	
6. If discharged, clinical condition at the time of discharge:	Recovered & discharged/ Expired/ Referred/ LAMA/ DAMA
7. Is the ailment a complication of Pre-existing disease or condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give details: _____
8. Is the present ailment attributable to the incurrence of alcohol or intoxicating drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Cause of Illness (if others, please specify):	<input type="checkbox"/> Congenital <input type="checkbox"/> Accidental <input type="checkbox"/> Pre-existing <input type="checkbox"/> Disability <input type="checkbox"/> Others _____

**Provide details if claim for disability**

1. Cause, nature & extent of disability		<input type="checkbox"/> Illness	<input type="checkbox"/> Injury
		<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary
		<input type="checkbox"/> Total	<input type="checkbox"/> Partial
2. If due to illness, please provide the following: Name of the illness: _____ Date of diagnosis of illness: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		If due to Accident, please provide the following: Date of Accident: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> Nature of Accident: RTA/ RSA Domestic Others If Others pls specify: _____	
Give cause of Injury/Accident:		<input type="checkbox"/> Self Inflicted <input type="checkbox"/> Road side / Road Traffic Accident <input type="checkbox"/> Under effect of Substance Abuse (incl. Alcohol)	
If Injury due to substance Abuse /Alcohol Consumption, Test conducted to establish this: (If yes, attach reports)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Medicolegal:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reported to Police:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
FIR No : <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>			
If not reported to police , specify reason: _____			
3. Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Progress		<input type="checkbox"/> Partially Improved <input type="checkbox"/> Unimproved <input type="checkbox"/> Fully recovered	
5. Treatment given during the course of hospitalization			
6. If discharged condition at the time of discharge (multiple options can be ✓)		Recovered & discharged/ Expired/ Referred/ LAMA/ DAMA	
7. As per condition at discharged, what was the expected time of recovery?			
8. Has the insured followed all recommendations?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly	
Please describe in detail any complications, RELATED to injury that may have occurred after discharge;			
Please describe in detail any complications, NOT RELATED to injury that may have occurred after discharge and worsened clinical condition			

**Past history of the insured**

1. Was the patient suffering from any illnesses in the past?	Nature of illness	Yes/No		Duration
	Hypertension	Y	N	
Diabetes	Y	N		
Tuberculosis	Y	N		
Kidney disease	Y	N		
Liver disease	Y	N		
Heart disease	Y	N		
Cancer	Y	N		
Asthma/COPD	Y	N		
Others	Please Specify: _____			



## Declaration

We hereby declare that the details furnished in this form are true and correct to the best of our knowledge and belief and is as per the records of the hospital

Certification by Hospital Admitted, that

1. The Hospital is duly registered as a Hospital to provide treatment in India for the care and treatment of sick and injured persons as registered in-patients, fully equipped with facilities for diagnosis and major surgery which are under the constant supervision of one or more Registered Medical Practitioners and which have 24-hour a day full time professional nursing services; and

2. Maintains proper medical and patient records; and

3. The Hospital has on the following facility and resource (Please specify)

Hospital Registration No : \_\_\_\_\_

No. of In-patient beds (including ICU) : \_\_\_\_\_

No. of fully equipped Operation Theatre in the Hospital : \_\_\_\_\_

No. of qualified nursing staff in Hospital round the clock : \_\_\_\_\_

No. of qualified medical practitioner (s) in charge round the clock : \_\_\_\_\_

Doctor's Name & Qualification: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor registration no. & contact no.

\_\_\_\_\_  
\_\_\_\_\_

Address & Seal (to be attested with hospital seal):

\_\_\_\_\_  
\_\_\_\_\_

Hospital Seal