

Without prejudice

**Important points:**

- This form needs to be completed by the doctor who has treated the Life Assured in the past and for the last illness suffered
- Please enclose Copies of all medical records of treatment / consultation notes wherever applicable, along with this certificate

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

Name of the Patient / Life Assured: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Pin code: \_\_\_\_\_

Is/Was the Life Assured/Patient related to you?  Yes  No If yes, how: \_\_\_\_\_

How long have you known the Life Assured: \_\_\_\_\_

**Details of consultation**

Date of first / consultation

Was he/she treated as an In-Patient or Out-Patient? \_\_\_\_\_

Consulted for \_\_\_\_\_

Consultation during last illness suffered:	
When the ailment was first diagnosed?	
What were the symptoms?	
Was it an acute ailment or complication of some chronic ailment?	
Was it acute-on-chronic presentation of some chronic ailment?	
Duration of complaints:	
What were the investigation undergone by the Life Assured & Where were the test performed?	Investigation done: _____ Name & Address of the Pathology Lab: _____
Treatment given by you?	_____
Was the Life Assured referred from any doctor or hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please provide us with the following) Name & Address: _____ Tel. No.: _____
Was the Life Assured referred to any doctor or hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please provide us with the following) Name and Address of the referred Doctor/Hospital: _____ Tel. No.: _____
Diagnosis based on tests conducted and evaluation	

Pls provide details of past medical history	<b>Nature of illness</b>	<b>Yes/No</b>		<b>Duration</b>	<b>Whether last illness treated was a known complication/ sequel of this past medical history?</b>
	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: _____			

Habits & personal history	<b>Habits</b>	<b>Yes/No</b>		<b>Duration</b>	<b>Quantity consumed</b>
	Consumption of alcohol	Y	N		
	Smoking	Y	N		
	Tobacco	Y	N		
	Drugs	Y	N		
	Drugs of abuse consumption	Y	N		

Was the insured ever asked to stop the above habit:  Yes  No

If Yes: Pls share the Reason

3. Did the patient undergo any surgery in the past and or now due to the current illness?

Yes  No

If yes, provide the following details:

Name of the surgery: \_\_\_\_\_

Indication for Surgery: \_\_\_\_\_

In case any biopsy done, finding of HP report: \_\_\_\_\_

Final Diagnosis arrived at: \_\_\_\_\_

Name of the hospital where the surgery was performed: \_\_\_\_\_

Date on which surgery was performed:

4. Who reported the above mentioned history

**Whether the Life Assured has availed the benefit of any Medical Insurance policy for the purpose of making payment. If yes, please provide details**

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**In case of death please provide us with the following details**

Date of death?	<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"/>
What was the Immediate cause of death	
Underlying cause of death	

