TREATING DOCTOR'S CERTIFICATE



Without prejudice

Important points:

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

Policy No.:	Date: D D	M M Y Y Y
Name of the Patient / Life Assured:		Age:
Address:		
	Pin code	
Is/Was the Life Assured/Patient related to you? Yes Now long have you known the Life Assured:	lo If yes, how:	
now long have you known the the 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	Investigation done:	
Assured &		
Where were the test performed?	Name & Address of the Pathology Lab:	
Treatment given by you?		
Was the Life Assured referred from any doctor or hospital?	Yes No (If yes, Please provide us with	the following)
	Name & Address:	
	Tel. No.:	
Was the Life Assured referred to any doctor or hospital?	Yes 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	Nature of illness		Yes/No		Duration		Whether last illness treated was a known complication/ sequel of this past medical history?			
	Hypertension		Υ	N						
	Diabetes		Υ	N						
	Tuberculosis		Υ	N						
	Kidney disease		Υ	N						
	Liver disease		Υ	N						
	Heart disease		Υ	N						
	Cancer		Υ	N						
	Asthma/COPD		Υ	N						
	Others		Please Specify:							
Habits & personal history		Habit	its			Yes	/No	Duration	Quantity consumed	
		Consu	ımption	of alcoh	ol	Υ	N			
		Smoki	ing			Υ	N			
		Tobac	со			Υ	N			
		Drugs				Υ	N			
			of abus mption	of abuse nption Y			N			
Was the insured ever asked to stop the ab	ove habit: Yes	No			,					
If Yes: Pls share the Reason										
3. Did the patient undergo any surgery in the past and or		Ye	Yes No							
now due to the current illness?		If yes,	yes, provide the following details:							
	Nam		Name of the surgery:							
Indica		Indication for Surgery:								
	In cas		In case any biopsy done, finding of HP report:							
Final		Final [Final Diagnosis arrived at:							
Name of the hospital where the surgery was performed:										
Date		Date of	Date on which surgery was performed: DD MM YYYY							
4. Who reported the above mentioned h	4. Who reported the above mentioned history									
Whether the Life Assured has availed th	e benefit of any Med	ical Insu	rance po	olicy for	the pu	urpose	of makin	ng payment.		
If yes, please provide details										
In case of death please provide us with	the following details									
Date of death?			D D	M	M	YY	YY			
What was the Immediate cause of death	th									
Underlying cause of death										

In Case of disability please provide us with the following details						
Nature of disability	Permanent Temporary					
Extent of disability	Total Partial					
Cause of Disability	Illness Accident					
If due to illness, please provide the following:	If due to Accident, please provide the following:					
Name of the Illness:	Date of Accident: DDDMMMYYYYY					
Date of diagnosis of illness: DD MM YYYY						
Give cause of Injury/Accident:	Self Inflicted; Road traffic; Road side; domestic;					
	Others; under influence of Substance Abuse (incl Alcohol)					
	If Others pls specify:					
If Injury due to substance Abuse /Alcohol Consumption, Test conducted to establish this:	Yes No					
If Medicolegal:	Yes No					
ii Medicolegai.	Yes No					
Reported to Police:						
FIR No :	If not reported to police , give reason:					
Tim Ne .						
Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	Yes No					
Name & Address of hospital where the Life Assured was admitted						
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						
Doctor's Name & Qualification:						
Doctor's Signature: Date:						
Doctor registration no. & contact no.						
Address & Seal (to be attested with hospital seal):						
	Hospital Seal					