

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="DD"/> <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/> <input type="text" value="YYYY"/>	Date of discharge: <input type="text" value="DD"/> <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/> <input type="text" value="YYYY"/>
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="DD"/> <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/> <input type="text" value="YYYY"/> to <input type="text" value="DD"/> <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/> <input type="text" value="YYYY"/>
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="DD"/> <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/> <input type="text" value="YYYY"/>
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 _____

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