

WITHOUT PREJUDICE



**SBI LIFE INSURANCE COMPANY LIMITED**

**Medical Attendant's Certificate**

(To be completed by the Medical Attendant of the Life Assured in his last illness)

Policy No. \_\_\_\_\_

**Part I**

Name of Patient (Life Assured): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Part II**

Was the patient related to you? Yes / No

If yes, How? \_\_\_\_\_

**Part III**

Date of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Place of Death (Please provide the full address)

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

Cause of Death \_\_\_\_\_

Primary Cause \_\_\_\_\_

Secondary Cause \_\_\_\_\_

Cause of death Natural / Accidental / Others

If Others, Please Specify \_\_\_\_\_

Duration of illness \_\_\_\_\_

Symptoms of illness \_\_\_\_\_

Please provide the date on which you first examined/treated the patient \_\_\_\_\_

Please provide the period of consultation from \_\_\_\_\_ to \_\_\_\_\_



**WITHOUT PREJUDICE**

"The information is based on records maintained in the Register No. \_\_\_\_\_ Entry No. \_\_\_\_\_  
dated \_\_\_\_\_"

I \_\_\_\_\_ Medical Attendant of the deceased \_\_\_\_\_

DO HEREBY solemnly DECLARE that the above statements are true and correct to the best of  
my knowledge and belief and that the deceased did not die by his own act.

Place \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

**Signature & Stamp of Medical Attendant with the registration no.**

Signature : \_\_\_\_\_

Qualification: \_\_\_\_\_

Name of the Doctor : \_\_\_\_\_

Designation: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_