SBI Life INSURANCE With Us, You're Sure

WITHOUT PREJUDICE

Medical Attendant's Certificate

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

(a) Form to be filled in English only
(b) Kindly fill up the form complete in all respects and accompanied by relevant documents, original or certified photocopies of the records or documents
(c) Kindly be legible in filling up the form and ensure all information is declared correctly and clearly. DO NOT leave any column blank

Please note that the Claimant has already consented to share the Medical papers/details with the Insurance Company

Policy Number ___________________________ **Patient Registration No/IP 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 **Natural / Accidental / Others**

If Others, Please Specify _____________________________

Primary Cause of Death _____________________________

Secondary Cause of Death _____________________________

Duration of illness ____________________________

Symptoms of illness ______________________________

The date on which you first examined/treated the patient _________________________

The period of consultation by you from _____________ to ____________

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Part IV

Were the Life Assured's habits regular and moderate? **Yes / No**
If No, Please provide the details:

Nature of Habits	Duration (in years)	Quantity per day
Smoking		
Tobacco Consumption		
Alcohol Consumption		

Was Life Assured's health Regular and Normal **Yes/No**

If No, Please provide details – Did the Life Assured suffer from any of the following:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Kidney Disease ☐ Liver Disease ☐ Cancer ☐ Others

If Any Others, Please specify ________________________________

What were the other diseases that co-existed or preceded with the terminal illness

History of such diseases: ________________________________

Date when first observed: ________________________________

By whom treated? ________________________________

By whom the above history was reported to you? ________________________________

Provide Discharge / Treatment Summary and Treatment Records/Papers for the above.

Part V

Are you the family doctor for the deceased? **Yes / No**
If yes, for How long? ________________________________

If not, Please provide the name and address of his family doctor ____

When and for what ailments did you treat the deceased preceding his last illness? ____

Did you know any other medical practitioner/Hospital who attended the deceased? **Yes / No**
If yes, please provide their names and addresses
____________________ ____

Was any Post Mortem Examination of the body done? **Yes / No**

"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: ________________________

Name of the Doctor: _________________ Qualification: _____________________

Registration No. _____________________ Designation: _____________________

Address of Hospital / Clinic: ____________________________

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Contact No: ____________________________

Stamp of the Clinic / Hospital / Doctor