SBI Life
Apne liye. Apno ke liye.

WITHOUT PREJUDICE

# MEDICAL ATTENDANT'S CERTIFICATE

*(To be completed by the Medical Attendant of the Life Assured in his/her 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 : D D M M Y Y Y Y

Address : _____

_____

Occupation : _____

## PART II

Was the patient related to you? ☐ Yes ☐ No

If yes, How? _____

## PART III

Date of Death : D D M M Y Y Y Y

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 D D M M Y Y Y Y

The period of consultation by you from D D M M Y Y Y Y to D D M M Y Y Y Y

## 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 | | |

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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 | D | D | M | M | Y | Y | Y | Y | "

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/her own act.

Date | D | D | M | M | Y | Y | Y | Y |

Place _____

Name of the Doctor: _____ Qualification: _____

Registration No. _____ Designation: _____

Address of Hospital / Clinic: _____

_____

Contact No: _____

Certifying Doctor Signature with Stamp of the Clinic / Hospital