



MEDICAL ATTENDANT'S / HOSPITAL CERTIFICATE
(Format AI - Death Claim)

Policy Number:

Date: _____

1. Personal details of the Patient (Life Assured):

| | |
|---------------|--|
| Name | |
| Date of Birth | |

2. Details of Hospitalization / Treatment:

| | |
|---------------------------------------------------------|-------|
| Name, Address & Tel. No. of referring Doctor | |
| Was he / she treated as an In- patient or Out -patient? | _____ |
| Date of Admission/consultation | |

3. History reported at the time of admission / consultation:

| | |
|---------------------------------------------------------------------------------------|--|
| Details of illness / Symptoms | |
| Duration of the above | |
| Date of Diagnosis | |
| Name, Address & Tel. no. of the Doctor / Hospital who diagnosed / treated the patient | |
| Habits such as drinking, smoking quantity & duration) | |
| History Provided by (Patient himself / family member / other) | |
| History Recorded by | |

4. Details of diagnosis made by you / your hospital:

| | |
|-----------------------------------------------------------------|--|
| Provisional diagnosis | |
| Date of provisional diagnosis | |
| Tests done and results of the same for confirming the diagnosis | |
| Final diagnosis | |

| | |
|------------------------------------------------------------------------|--|
| Date of final diagnosis | |
| Treatment given | |
| Duration of the treatment | |
| Date of discharge / death | |
| If discharge, then condition at discharge & advice given for follow up | |

5. Details relating to death of the patient in case he / she was last seen / treated by you / your hospital:

| | |
|----------------------------------------------------------------------------------------------------------|--|
| Primary cause of death | |
| Secondary cause of death | |
| Were these causes ascertained by examination after death or from the symptoms & appearances during life? | |
| Complaints / Symptoms just before the death | |
| Duration of these symptoms | |
| Was a Post Mortem recommended? If yes, please specify reason for the same | |

6. Had the patient been admitted or treated by you or your hospital earlier? If yes, please provide the following details:

| Date | | In – Patient / Out - Patient | Reason for seeking treatment | Treatment given |
|------|----|---------------------------------|---------------------------------|-----------------|
| From | To | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Signed at _____ this _____ day of _____ 20____

Signature & Name of the Medical Attendant / Authorized Signatory:

Name of the hospital: _____

Address : _____

Tel no : _____

Stamp & Registration no.:

Note: Please attach copy of the records