

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

**Policy Number** \_\_\_\_\_

**Date :** \_\_\_\_\_

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

Name	
Date of Birth	
Father's name	
Address and contact number	

**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	
Date or Duration or Since when	
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 of the Employer:

*Note: Please attach copy of the records*