LIFE GOALS. DONE.

Attending Physicians Statement For Dread Disease/ Critical Illness Benefit Claim Form

(A qualified and registered medical practitioner should complete this form. Policy Holder, Life Insured who are also medical practitioners or their Spouse, or Lineal Relative of Policy Holder/Life assured cannot fill it)

I. General Information

1 a) Name of the Patient _____ b) Age _____

2.Are you the patient's usual doctor? If "yes", please give details. How long have you known the Patient?
Date of consultation _____ Diagnosis _____ Treatment given _____

3.Was the patient referred to you by another doctor or hospital? If "Yes", please give details:

Name of doctor/ hospital _____ Address of doctor/hospital _____

II. Information about the Dread Disease/Critical Illness

1. Exact Diagnosis _____
2. Date of First Consultation _____
3. Date of Diagnosis _____
4. Date of Surgery _____
5. History of Present Illness _____
6. Any other past Medical History _____
7. What is the prognosis _____

III. Other Information

1. Name and address of hospital where patient was admitted: _____
2. Date of Admission _____ 3. Date of Discharge _____
3. Any other information, which in your opinion will assist us in a assessing this claim? If "Yes", please give details below.

I _____ Medical Attendant of the Life Assured _____

_____ do hereby solemnly declare that the above statements are true and correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ 20 _____

Stamp of Medical Attendant

Signature of Medical Attendant _____
Name of Medical Attendant _____
Qualifications _____
Phone Number _____
Mobile No. _____ Email ID _____