LIFE GOALS. DONE.

Bajaj Allianz Life Insurance Physician's Certificate

NOTE:

1.Any change in ink/ overwriting should be countersigned by the Doctor

2.If the space provided in the boxes is inadequate, kindly attach annexure

3.To be completed in BLOCK letters by a duly quali ed and registered medical practitioner at claimant's expense

4.Please answer all questions, use not applicable (N/A) as appropriate

Section I (Contact details of Life Assured)

Name of the Life Assured:

Policy Number: Date of Birth: D D M M Y Y Y Y

Address:

Affix Life Assured's photograph

Contact no.* (STD Code) Mobile number:

*Contact details provided herein will be updated for all future communications. For customers registered under National Do Not Call Registry, this will be considered as consent to communicate with him/her on the contact details provided herein.

Section II (Medical Details of Life Assured)

Date of first consultation/admission	Symptoms/ Complaints	Date of commencement of symptoms/complaints	History provided and Recorded by

Details of Diagnosis

Exact Illness diagnosed	Date of diagnosis	Treatment given	Date of discharge I death

Details of Doctor/ Clinic

Name of the Doctor:

Name of the Clinic/Hospital:

Address of the Clinic/Hospital:

Contact no.* (STD Code) Mobile number:

Section III (Details of Pre- Existing OR Co- Existing I Chronic illness of Life Assured)

Did you treat I diagnose LA for any pre-existing I co-existing I chronic illness (Like Diabetes, Hypertension, Liver Cirrhosis, etc) Yes ☐ No ☐ (If yes then mention the details)	Symptoms/ Complaints	Treatment given

Section IV (Details of Pre- Existing OR Co- Existing I Chronic illness of Life Assured)

Exact name of the Surgery	Date of the Surgery	Name of the Surgeon	Address of the Surgeon	Contact Number	Qualification of the Surgeon

Section V (Details of Surgery (to be filled if surgery was performed on the Life Assured)

Name of Doctor	Name and Address of Clinic/Hospital	Contact Numbers	Date(s) of consultation (DD/MM/YYY)	Date(s) of Discharge (DD/MM/YYY)	Name of the Illness/diseases	Treatment given

Section VI (Details of Life Assureds' habits)

Substance	Form of Consumption	Quantity per Day	Nature of Consumption
Alcohol	**Beer** ☐ **Whiskey** ☐ **Wine** ☐ **Others** (Please Specify)_____	_____ **ML**	
Tobacco	**Cigarettes** ☐ **Bidis** ☐ **Chewing Tobacco** ☐	_____**No. of sticks/ packets**	
Others (Please Specify)			

Section VII (Additional Details)

Any other details that you would like to provide which will help us to process the claim under the policy

Declarations

1. I Undersigned do hereby declare that I was the doctor in attendance during the last illness of _____ and I hereby declare that whatever is stated herein above is true to the best of my knowledge, belief & information.
2. How long have you practiced as a physician?
3. Where did you receive your medical education and when?

Name of the Doctor:_____

Date: D D M M Y Y Y Y Place:_____

Address: _____

_____

Contact no. ☐☐☐☐☐☐☐☐☐☐ Qualification: _____ Registration No:_____

Please provide copy of medical records and OPD notes

Stamp