ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIMS - ACCIDENT

(This form is to be completed by the Medical Attendant of deceased who had last attended the injured insured. The Medical Attendant should be a qualified and registered medical practitioner.
Please attach separate sheets if required

Policy Number :

1) Full name, address & occupation of the deceased :

a) Name :

b) Address :

c) Occupation :

2) a) Age of Life Assured at the time of death : years

b) Was he/she related to you? : Yes No

c) How long had you known the deceased? :

3) a) Time of death : - a.m. / p.m.

b) Date of death : D D M M Y Y Y Y

c) Place of death (Address) :

4) a) Was the death of the Insured caused solely by injuries suffered by him in the accident? (If yes, give details) :

b) Was there any contributory cause of death or any antecedent ailment /disorder, including any psychic or mental disorder :

1. What were the exact complaints/ symptoms?

2. How long had he/she been suffering from this disease before death?

3. What was the date on which you were first consulted during the last illness? D D M M Y Y Y Y

4. What was the date of last attendance/follow up? D D M M Y Y Y Y

5) Was the deceased treated by any other medical practitioners or in any hospital before you were consulted? If yes, please give: :

Name

Address

6) Were you the deceased's usual family doctor? If yes, please state: -

a) For how long have you been known to the deceased? :

b) Date of Consultation :

c) Treatment given :

7) Since when was the deceased under any kind of medical care. What were the presenting complaints? If yes, please give date and details : Date D D M M Y Y Y Y

Details

8) Please give details of treatment rendered in the past or for current Ailment : _____

9) Please provide details of all medical investigations conducted so as to confirm the diagnosis (attach separate sheets if required) : _____

10) When the diagnosis was finally confirmed? Since when did the deceased suffer from this ailment? : _____

11) Did the deceased suffer from any other ailment other than the ailment that eventually led to death? If yes please give the dates and details (attach separate sheets if required) : Date D D M M Y Y Y Y

Details _____

12) Was the accident reported to the police? If so, please furnish address of the police station to which the matter was reported : By Whom _____

Result/Findings _____

13) Was any Post Mortem Examination of the body made? If yes, Please give details (attach additional copies if required) : _____

14) Have you any other information/ to make in connection with this claim concerning deceased's ailments, habits, mode of living etc. : _____

15) To your best knowledge, please give names of other physicians or practitioners who have attended the deceased during the past 3-years.

Name of the Doctor	Address	Contact No	Date of Consultation	Disease/ Condition

I _____ Medical Attendant of the deceased _____ DO HEREBY SOLEMNLY DECLARE that foregoing statements are true and correct as per the records kept in the normal course by me/the hospital

Dated at _____ this _____ day of _____ 200

Signature of Medical Attendant : _____

Name of Medical Attendant : _____

Stamp of Medical Attendant/ Hospital : _____

Qualification(s) of the Medical Attendant : _____

Postal Address : _____

_____

Telephone number (with STD Code) : _____ _____