HOSPITAL TREATMENT CERTIFICATE – NON ACCIDENTAL DEATH CLAIM

Claim under policy no _____ on the life of (Full Name of the Deceased) _____

Following information should be based on Hospital Records

1) a) Name : _____

b) Age : ____ Years

c) Occupation : _____

d) Address : _____

e) Identification mark (if any) : _____

2) a) Date of Admission : D D M M Y Y Y Y b) Time _____

c) Admission number : _____

3) Nature and Duration of illness reported at the time of Admission : _____

4) If the patient was referred to you, please state the Name & Address of the Hospital/ Doctor concerned. : _____

5) a) History of illness reported at the time of admission : _____

b) Who reported the history? : _____

c) Please give details of doctor who recorded the history : _____

6) Please provide details and dates of the investigations and tests conducted during the stay in the hospital. (if so please attach copies) : D D M M Y Y Y Y _____

7) What was the diagnosis arrived at in the Hospital? : _____

8) Please give details of the treatment rendered to the deceased. Attach separate sheets if required : _____

9) Were there any other illness/ disease prior to or which coexisted with the ailment at the time of admission into the hospital. Give brief particulars of it. : _____

10) Date of his/her discharge from Hospital : D | D | M | M | Y | Y | Y | Y

11) Condition at the time of discharge: _____

12) Was he/she treated in the hospital on any previous occasion for the last illness or any other illness? If yes, please give details : _____

Certified that the above information is correct as per records of the Hospital

Date : D | D | M | M | Y | Y | Y | Y Signature: _____

Name of the Doctor : _____

Code No : _____ Qualification and designation : _____

_____

Name of the Hospital : _____

Postal Address of the Hospital : _____

_____

_____

Telephone Number (with STD code) : | | | | | | | | | | | |

Hospital Seal/ Stamp _____