DC20018081109

Doctors Certificate

For Official Use Only

Date of Receipt: Time of Receipt:

Received by:

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 qualified 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

Address: _____

Contact No.* (STD Code) _____/ (STD Code) _____/_____Mobile Number.

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 / death

(Details of Doctor/ Clinic)

Name of the Doctor: _____ Name of the Clinic/ Hospital: _____

Address of the Clinic/Hospital: _____

Contact No. (STD Code) _____/ (STD Code) _____/_____

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

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

Section IV Details of Surgery (to be filled if surgery was performed on the 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 Number's	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:_____ Place:_____

Address: _____

Contact No.:_____

Qualification:_____ Registration No:_____

Please provide copy of medical records and OPD notes

STAMP