

# ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIMS

(This form is to be completed by the Medical Attendant of deceased during the last illness)

A qualified & registered physician should complete this form. Please attach separate sheets if required. This form should be filled in on the basis of the information available from the records maintained by the doctor.

Claim under Policy Number	: <table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table>																				

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? If so, How?	:	_____								
c) How long had you known the deceased?	:	_____								
3) a) Time of death	:	_____ - _____ a.m. / p.m.								
b) Date of death	:	<table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 5%;">D</td><td style="width: 5%;">D</td><td style="width: 5%;">M</td><td style="width: 5%;">M</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
c) Place of death	:	_____								
4) a) What was the immediate cause of death?	:	_____								
b) Was there any contributory cause of death or any antecedent ailments	:	If yes, give details _____ _____								
c) What were the exact complaints/ symptoms?	:	_____								
d) How long had he/she been suffering from this disease before death?	:	_____								
e) What was the date on which you were first consulted for the last illness?	:	<table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 5%;">D</td><td style="width: 5%;">D</td><td style="width: 5%;">M</td><td style="width: 5%;">M</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
f) What was the date of last consultation/follow up?	:	<table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 5%;">D</td><td style="width: 5%;">D</td><td style="width: 5%;">M</td><td style="width: 5%;">M</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
5) Was the deceased treated by any other medical	:	_____								
Name practitioner or in any hospital before you were consulted? If yes, please give	:	_____								
Address	:	_____								
6) Were you the deceased's usual doctor?	:	_____								
If yes, please state: -	:	_____								
a) For how long	:	_____								
b) Date(s) of Consultation	:	1) _____ 2) _____								
c) Treatment given	:	_____								
7) Since when was the deceased under any kind	:	_____								
Date of medical care. What were the complaints	:	_____								
Details	:	_____								
8) Please give details of treatment rendered in the past and for last illness	:	_____								
9) Please provide details of the investigations conducted and tests undergone so as to confirm the diagnosis (attach separate sheets if required)	:	_____								
10) a) When was the final diagnosis made?	:	_____								
b) Since when did the deceased suffer from this ailment?	:	<table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 5%;">D</td><td style="width: 5%;">D</td><td style="width: 5%;">M</td><td style="width: 5%;">M</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td><td style="width: 5%;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			

- 11) Did the deceased suffer from any antecedent illness?? If yes please give the details (attach separate sheets if required) : \_\_\_\_\_
- 12) Was any Post Mortem Examination conducted? : If yes, Please give the cause death as per the Post Mortem Report \_\_\_\_\_
- 13) Have you any other information/ to be shared : with us in connection with this claim concerning deceased's s, habits etc. \_\_\_\_\_

14) Can you give names of the other Medical practitioners who had attended the deceased during the last 3-years?

Name of the Doctor	Address	Contact No	Date of Consultation	Diagnosis arrived at

I Medical Attendant of the deceased do hereby declare that foregoing statements are based on the records maintained in the normal course of my profession

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20

Name of Medical Attendant : \_\_\_\_\_

Qualification(s) : \_\_\_\_\_

Postal Address : \_\_\_\_\_

Stamp of Medical Attendant : \_\_\_\_\_

Signature of Medical Attendant : \_\_\_\_\_

Telephone number (with STD Code) : \_\_\_\_\_



Bharat Ki Udaan, Bandhan Se.



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