Aditya Birla Sun Life
Insurance Company Ltd.

ADITYA BIRLA CAPITAL
LIFE INSURANCE

Attending Physician's Certificate Critical Illness Rider

(Questionnaire to be completed by the specialist who has treated the life insured for illness)

Policy Number: ☐☐☐☐☐☐☐☐☐ Date: D D M M Y Y Y Y

Name of Patient: _____

Age: ☐☐ Date of Birth: D D M M Y Y Y Y Occupation: _____

Any identification Marks: _____

Admission: _____ Date: D D M M Y Y Y Y Time: H H M M A.M / P.M.

Patient History: _____ Discharge Date: D D M M Y Y Y Y

Examination and Diagnosis:

1) Kindly describe in brief the symptoms of the illness noticed on examination?

_____

2) How long do you believe the symptoms had been present when you were first consulted?

_____

3) Were the symptoms noticed on examination consistent with the history reported on consultation/admission?

_____

If not, please state what in your opinion could have caused the illness.

_____

4) Is there anything in the family history which would have increased the risk of his condition?

_____

5) What was the final diagnosis and when was the patient informed about it?

_____

Please give objective findings supporting the diagnosis and prognosis (include any results of histopath, current x-rays, E.C.G., MRI or any other special tests with dates).

To be filled only in case of surgeries performed on the life insured

Date of surgery: D D M M Y Y Y Y Nature of surgery: _____

Performed by: _____

Hospital Name: _____

Hospital Address : _____

_____ Contact No.: _____

Treatment:

1) Kindly give particulars of treatment given? _____

2) What is the present condition of the patient? _____

If there is any further information, which in your opinion will assist us in assessing this claim, please furnish the information below:

Name of the Doctor: _____

Registration no of the Doctor: _____

Address: _____

Mobile (Mandatory): | | | | | | | | | | Telephone (R/O) No.: STD code | | | | | | | | | |

Email Id: _____

DECLARATION

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy. Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned address:

FOR/11/17-18/1117

Signature & Seal: _____ Place: _____ Date: D D M M Y Y Y Y

Aditya Birla Sun Life Insurance Company Limited Registered Office: One World Centre, Tower 1, 16th Floor, Jupiter Mill Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai - 400 013. IRDAI Reg No.109 | CIN: U99999MH2000PLC128110 Toll free no. 1-800-270-7000 https://lifeinsurance.adityabirlacapital.com

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Aditya Birla Sun Life
Insurance Company Ltd.

ADITYA BIRLA CAPITAL
LIFE INSURANCE

To be completed by Attending Physician – Part B

Policy Number: | | | | | | | | | | |

Name of Life Insured: _____

Date of Birth: D D M M Y Y Y Y Age: | |

Occupation (including description of duties): _____

Last day at work: _____ Qualification: _____

Date of Admission: D D M M Y Y Y Y Time of Admission: H H M M

MEDICAL HISTORY

1. Diagnosis and reason for claim: _____
2. Date when the symptoms started: _____
3. Date when Life Assured first seen by you for this reason: _____
4. Date when Life assured stopped work: _____
5. Date when life assured was seen by you for any other conditions (please give dates and details below):

_____

Date	Reason for Consultation	Treatment Prescribed	Duration of Complaint

MEDICAL REFERENCES

Please give the details of any other Practitioners, Specialists or Hospitals to who the claimant has been referred. Please include copie of all available Specialist reports

Name of Practitioner / Hospital	
Speciality	
Postal Address & Contact No.	
Complaints referred for	
Date of Referral	

Medical History

Please give full medical history, including the following.

- Symptoms and diagnosis
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. lung function readings, X-ray or scan results)
- Treatment and response
- Other comments

Current major complaint(s) _____

Please comment on the member's ability to carry out the specified activities in the table below.

ACTIVITY	CURRENT LIMITATIONS				EXPECTED FUTURE ABILITY		
	No Limitation	Partial Limitation	Impossible	Danger to self and others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly and making decisions							
Interacting with others							
Walking (non-strenuous) over level grounda							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Use of both arms and legs							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							
Bathing							

Dressing							
Getting in and out of bed							
Maintaining personal hygiene							
Feeding onself							
Getting between rooms							

RESULTS OF MOST RECENT MEDICAL EXAMINATION

Date of Birth: D D M M Y Y Y Y

Please give full clinical details as at the examination, including height, weight, and blood pressure readings. Please include details of any limitations evident at the examination (e.g. joint limitations, visual acuities).

PROGNOSIS

What are chances of recovery Good/Fair/Poor/Nil)? _____

Are any residual problems likely? Please specify: _____

_____

Date expected to return to work: D D M M Y Y Y Y

DOES THE CLAIMANT USE TOBACCO IN ANY FORM? Yes ☐ No ☐ If "yes" please provide details:

_____

_____

_____

IS CURRENT MEDICAL IMPAIRMENT DUE TO:

a) Previous illness or injury Yes ☐ No ☐

b) The intentional consumption of alcohol, narcotics or any toxic substance Yes ☐ No ☐

c) Attempted suicide or any self-inflicted injury Yes ☐ No ☐

General comments, which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated.

_____

_____

If period off work longer than usually expected for impairment, please give reason.

_____

_____

TREATMENT AND REHABILITATION

Current treatment regime. Please specify all medications and dosages:

_____

_____

Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy):

Planned future treatment, including surgery:

Your recommendations regarding rehabilitation (if applicable)

Name of Doctor: _____ Registration Number _____

Postal Address: _____

Landline No.: ☐☐☐☐☐☐☐☐☐☐ Mobile No.: ☐☐☐☐☐☐☐☐☐☐

Email address: _____ Qualification: _____

VERNACULAR DECLARATION:

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I confirm that no information that could influence a decision regarding this claim has not been withheld. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.

Full Signature of Doctor: _____ Date of Report: D D M M Y Y Y Y

Any confidential information, which in your opinion should be in the possession of the Company, should be forwarded to Head Office at the below mentioned address.

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