LIFE INSURANCE

Aditya Birla Sun Life Insurance Company Limited

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Personal Medical Abstracts (PMA) Disability Claims

Request For An Abstract From Clinical Records

Policy Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Name: _____ Age: ☐☐ Contact No: ☐☐☐☐☐☐☐☐☐☐

Address: _____

_____

Group Policy Number	Member Name	Doctor
☐☐☐☐☐☐☐☐☐☐☐		

1. Although we would like short notes of all sickness however minor we would appreciate your detailed comments regarding:

   General History

   _____

   _____

2. Please give the dates of your patient's first and last consultations

   First Consultation: _____

   Last Consultation: _____

   Hospital Member Name: _____

3. Date and Duration — Reason for Consultation, Diagnosis, Treatment and Results

   D D M M Y Y Y Y _____ _____

   D D M M Y Y Y Y _____ _____

   D D M M Y Y Y Y _____ _____

   D D M M Y Y Y Y _____ _____

   D D M M Y Y Y Y _____ _____

4. To the best of your knowledge is the patient now unable to work? ☐ Yes ☐ No

   What is the prognosis?

   _____

5. To the best of your knowledge have any of the above illnesses resulted in your patient being frequently absent from work?

   _____

6. If any additional or special examinations have been carried out or you have referred your patient to any other doctor or hospital please give details. Kindly provide copy of the ECG's or reports which will be returned to you after use?

   _____

7. (a) Is there any reason to believe that your patient's illness, disorder or inability to follow a remunerative occupation is in any way due to or arises directly or indirectly, entirely or partially from AIDS or HIV infection? ☐ Yes ☐ No

If "yes" please give full details: _____

_____

(b) Has your patient ever been tested for HIV antibodies? ☐ Yes ☐ No

If "yes" what was the result of the test? _____

_____

8. Are you aware of any factors relevant to your patient's family history, present health, medical history or habits which in your opinion may affect our assessment?

_____

_____

Medical Attendant and Hospital Details:

Name of the doctor: _____

Address: _____

_____

Contact no: ☐☐☐☐☐☐☐☐☐☐

Registration no: ☐☐☐☐☐☐☐☐☐☐☐☐

Hospital Name: _____

Hospital Address: _____

_____

Hospital Contact No: ☐☐☐☐☐☐☐☐☐☐

Declaration:

I/We agree that aforesaid answers and statements made by me/us are true and correct. Further, I agree that the Company reserves the right to call for additional document/requirements in relation to the Life Assured/said Patient.

_____

Signature:

Date: D D M M Y Y Y Y

Place: _____