Aditya Birla Sun Life
Insurance Company Ltd.

ADITYA BIRLA CAPITAL
LIFE INSURANCE

Medical Attendant's Certificate (Death Claim)

Dear Sir / Madam,
You are requested to duly fill this form (as per the treatment records - attach relevant case papers) to enable Aditya Birla Sun Life Insurance Company Limited (ABSLI) to process the Claim in respect of the deceased Life Assured promptly. Thanking you for the support and co-operation extended.

Policy Number/s: ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

Name of the deceased in full: _____ Age: ☐☐ (Years)

Address of the deceased: _____

_____

Date of Death: D D M M Y Y Y Y Time of Death: H H : M M AM/PM Place of Death: _____

Cause of Death: (a) Immediate: _____ (b) Primary: _____

1. Are you the regular attending physician of the deceased as mentioned above? YES ☐ NO ☐
   If Yes, since how long had you been acquainted with him / her? _____
2. Please provide the following information:
   (a) Was the deceased a Smoker? YES ☐ NO ☐
   (b) If yes, mention average consumption per day : _____
   (c) Was the deceased consuming alcohol? YES ☐ NO ☐
   (d) If yes, mention average consumption per day : _____
3. When and for what illness did you last treat him / her and for what duration? _____
4. State exact duration of last illness prior to death _____
5. (a) Was the deceased hospitalized during his illness? YES ☐ NO ☐
   (b) If yes, kindly fill in the details of the hospital and patient as per hospital records?
   Patient Name: _____
   Name of the Hospital: _____ Registration Number: _____
   Address of the Hospital: _____
   Admission Date: D D M M Y Y Y Y Discharge Date: D D M M Y Y Y Y IP No. _____
6. Describe the presenting complaints, duration of ailment of the deceased on the date of 1st consultation/admission.
   _____
7. Kindly provide copies of indoor case papers with the findings of the investigations done:

Types of Tests conducted	Date of Test conducted	Laboratory where the tests were conducted	Findings

8. What was the final diagnosis and when was it made? (Please provide the exact dates)
   _____
9. Did the patient suffer from similar or any other diseases/conditions in the past? YES ☐ NO ☐
   If yes, give details in the following format:

Dates of Consultation/ Hospitalization	Names of Doctors/ Hospitals	Nature Of Illness	Diagnosis	Treatment details

10. Did previous illness, family history or habits in any way predispose to the cause of death or aggravate the Illness? If yes, describe fully.

_____

11. If you were not the attending physician during the deceased's last illness/ not present when death occurred; kindly provide details of the name, contact details and address of the medical attendant present then.

_____

_____

12. Was a Post Mortem examination conducted? YES ☐ NO ☐ , if yes, please provide details.

_____

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.

Name of the Doctor: _____

Registration Number: _____

Address: _____

_____

Contact Details:

Phone No.: ☐☐☐☐☐☐☐☐☐☐ Mobile No.: ☐☐☐☐☐☐☐☐☐☐

Fax No.: ☐☐☐☐☐☐☐☐☐☐ E-mail Id: _____

Sign and stamp of the Doctor: _____ Date: D D M M Y Y Y Y

Place: _____

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/10/17-18/999

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