

# Medical Attendant's Statement - Form B

IRDA REGN. NO. 142

Date: \_\_\_\_\_

- 1) Name of the Life Assured / Patient : \_\_\_\_\_
- 2) Address of the Life Assured : \_\_\_\_\_  
: \_\_\_\_\_
- 3) Are you a family physician?  
If yes, How long : \_\_\_\_\_
- 4) Date of Birth of Life Assured : \_\_\_\_\_
- 5) Nature of illness : \_\_\_\_\_
- 6) Duration of illness : \_\_\_\_\_
- 7) Onset of illness : \_\_\_\_\_
- 8) Date of final Diagnosis : \_\_\_\_\_
- 9) Treatment given : \_\_\_\_\_
- 10) Duration of treatment : \_\_\_\_\_
- 11) Past illness details : \_\_\_\_\_
- 12) Was the Life Assured in habit  
Of consuming tobacco / alcohol : \_\_\_\_\_  
If Yes, duration of consumption : \_\_\_\_\_
- 13) Are you aware of the amount  
Of tobacco / alcohol consumed  
Per day by the Life Assured : \_\_\_\_\_  
If yes, provide details : \_\_\_\_\_
- 14) Exact cause of death : 1. Primary cause : \_\_\_\_\_  
: 2. Secondary cause : \_\_\_\_\_
- 15) If post-mortem recommended,  
reason for the same : \_\_\_\_\_  
: \_\_\_\_\_
- 16) Place /date and time of death : \_\_\_\_\_
- 17) Anything hereditary related to the  
Life Assured you wish to disclose  
that might have affected the  
longevity in any manner : \_\_\_\_\_

**Star Union Dai-ichi Life Insurance Company Limited**

**Registered Office:** 11th Floor, Vishwaroop I.T. Park, Plot No. 34, 35 & 38, Sector 30A of IIP, Vashi, Navi Mumbai - 400 703.

☎: 18002668833 (Toll free) / 022-39546300 (landline) - 8:00 am to 8:00 pm (Mon - Sat).

Email: [customercare@sudlife.in](mailto:customercare@sudlife.in) | Website: [www.sudlife.in](http://www.sudlife.in) | IRDA Regn. No. 142 | C.I.No. U66010MH2007PLC174472

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I, \_\_\_\_\_, Medical Attendant of the deceased do hereby declare that all the statements given by me are best to my knowledge and in no way hide any information that I had about the deceased Mr. / Mrs. / Ms. \_\_\_\_\_ and the cause of death do not give any type of suspicion indicating that the deceased died out of his / her own act.

Place : \_\_\_\_\_

Date : \_\_\_\_\_

Witness to Medical Attendants : \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
Seal of the Clinic / Hospital

Identity and signature of Witness

Name of witness : \_\_\_\_\_

Address of witness : \_\_\_\_\_

Contact No. : \_\_\_\_\_

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

Address of Medical Attendant : \_\_\_\_\_

Contact No. : \_\_\_\_\_

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