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 : _____

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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. : _____