

# Medical Treatment Certificate from Hospital - Form C

IRDA REGN. NO. 142

- 1) Name of the Life Assured : \_\_\_\_\_
- 2) Address of the Life Assured : \_\_\_\_\_  
: \_\_\_\_\_
- 3) Date of Birth of Life Assured : \_\_\_\_\_
- 4) Complaint reported by deceased : \_\_\_\_\_
- 5) Whether reported in discharge card : \_\_\_\_\_
- 6) History of illness reported by patient : \_\_\_\_\_
- 7) On-set of above illness : \_\_\_\_\_
- 8) Treatment given here : \_\_\_\_\_
- 9) Duration of treatment given : \_\_\_\_\_
- 10) Was the Life Assured in habit  
Of consuming tobacco / alcohol : \_\_\_\_\_
- 11) Was the Life Assured ever got  
Admitted before in your hospital : \_\_\_\_\_
- 12) If Yes, Admitted for illness : \_\_\_\_\_
- 13) Previously treated : from \_\_\_\_\_ to \_\_\_\_\_
- 14) Name of the physician who  
Treated the Life Assured : \_\_\_\_\_
- 15) Diagnosis of the physician on  
the discharge card : \_\_\_\_\_
- 16) Date of admission & discharge : \_\_\_\_\_, \_\_\_\_\_
- 17) Incase of death, Date of death : \_\_\_\_\_
- 18) Place and Time of death : \_\_\_\_\_ am / pm
- 19) Any detail your hospital wish to share  
with regards to health of Life Assured : \_\_\_\_\_

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

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

Name of hospital : \_\_\_\_\_

Address of hospital : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Sign / Stamp / Seal of hospital

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

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