

Treatment Certificate from Medical Attendant: who treated in the
 last days of illness / immediate before death / who pronounced the death of policyholder : Form D

Following are the details of the Life Assured under policy no. _____

- 1) Name of the Life Assured : _____
- 2) Address of the Life Assured : _____
 : _____
- 3) Date of Birth of Life Assured : _____
- 4) Occupation of the Life Assured : _____
- 5) Nature of illness : _____
- 6) Duration of illness by patient : _____
- 7) On set of illness : _____
- 8) Treatment given : _____
- 9) Duration of treatment : _____
- 10) Was the Life Assured in habit
 Of consuming tobacco / alcohol : _____
- 11) Are you aware of the amount
 Of tobacco / alcohol consumed
 Per day by the Life Assured : _____
- 12) Duration of intake of details
 mentioned in 10 & 11 above : _____
- 13) Anything hereditary related to
 the Life Assured you wish to
 disclose that might have affected
 the longevity in any manner : _____

Place : _____

Date : _____

Name of the Medical Attendant : _____

Address of Clinic : _____

 Sign / Stamp / Seal of hospital

Star Union Dai-ichi Life Insurance Company Limited

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