IndiaFirst LIFE INSURANCE

PROMOTED BY Bank of Baroda | Andhra Bank

Treating Doctor's Certificate (To be completed by the doctor who treated / attended the Life Insured)

- To be completed in BLOCK letters by duly qualified registered medical practitioner at claimant's expense.

Personal Details of Life Assured

Full Name:

Policy number: Date of birth: D D M M Y Y Y Y

Nature of Illness Suffered (Please tick the relevant illness suffered by Life Assured)

- ☐ Open Chest CABG (Coronary Artery Bypass Graft Surgery)
- ☐ Major Organ or Bone Marrow Transplant (as recipient)
- ☐ Open Heart Replacement or Repair of Heart Valves
- ☐ Motor Neurone Disease with Permanent Symptoms
- ☐ Kidney Failure requiring regular dialysis
- ☐ Stroke resulting in Permanent Symptoms
- ☐ Coma with Severity
- Other (Please Specify) _____
- ☐ Alzheimer's Disease
- ☐ Heart attack
- ☐ Cancer

Details of Illness/Ailment

Name of Patient

Presenting complaints of illness / disease (With duration)

Final diagnosis

Details of Diagnostic Tests done and their findings.

Past Medical History (Related / Unrelated with current illness along with duration)

Date of First consultation / Admission

Date of first Diagnosis of illness

Habits such as Drinking, Smoking (quantity & duration)

History Provided by (Patient himself/ family member / other) Please specify

Treatment Given

Date of Admission (If Hospitalised) D D M M Y Y Y Y Date of Discharge (If Hospitalised) D D M M Y Y Y Y

Has the patient ever suffered with this or any similar condition before the present episode?

Please fill in this section if the Ailment suffered is due to Accident

Date of Accident : D D M M Y Y Y Y FIR/ Case No: Place of Accident: _____

Type of Accident: Road accident ☐ Accident at home ☐ Accident at work ☐ In case of other, please specify _____

How did the accident occur? _____

In case of physical severance of Limbs please select relevant details: (Please tick the relevant option)

Upper Limbs	Right	Above Wrist	Below Wrist
	Left	Above Wrist	Below Wrist
Lower Limb	Right	Above Ankle	Below Ankle
	Left	Above Ankle	Below Ankle

In case of loss of sight in eyes please select relevant details: (Please tick the relevant option)

	Vision			Acuity
Right Eye	Total Loss	Near Total Loss	Partial Loss	
Left Eye	Total Loss	Near Total Loss	Partial Loss	

Previous treatment, hospitalizations, Surgery or admission details (If 'YES' kindly provide us the details)

Dates		In Patient / Out Patient	Reason for medical treatment	Treatment Given	Diagnosis Made
From	To				

I Undersigned do hereby declare that I was the doctor in attendance during the last illness of _____ and I hereby declare that whatever is stated herein above is true to the best of my knowledge, belief & information.

Name of Doctor_____ Qualification _____ Contact Numbers _____ Date D D M M Y Y Y Y

Name & Address of Hospital _____

Signature & Seal of Treating Doctor:

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