CERTIFICATE FROM HOSPITAL (DEATH)

edelweiss life insurance

Without prejudice

Important points:

- This form needs to be completed by the Hospital Authorities where the Life Assured was either admitted or treated
- If the Life Assured has been admitted in two different hospitals the form is to be filled up per hospital
- Medical records such as Death/Discharge Summary, Inpatient / Outpatient records, Operation notes, Progress records wherever applicable to be provided along with this form

Policy No.: _____ Date: D D M M Y Y Y Y

Name of the Patient: _____ Inpatient No./MRD No.: _____

Address: _____ Age: ____ years

Details of the hospital

1. Reason for hospitalization: _____

2. Date of admission: D D M M Y Y Y Y

3. Date of Discharge/Death: D D M M Y Y Y Y

4. Was the patient referred by any doctor/Hospital?

☐ Yes ☐ No (If yes, Please provide us with the following)

Name & Address: _____

_____

Tel. No.:_____

5. Diagnosis

_____

6. Was the patient suffering from any illnesses in the past?

Nature of illness	Yes/No		Duration
Hypertension	Y	N	
Diabetes	Y	N	
Tuberculosis	Y	N	
Kidney disease	Y	N	
Liver disease	Y	N	
Heart disease	Y	N	
Cancer	Y	N	
Others	Please specify: _____		

7. Did the patient have habits like

Habits	Yes/No		Duration	Quantity consumed
Consumption of Alcohol	Y	N		
Smoking	Y	N		
Tobacco	Y	N		
Drugs	Y	N		

8. Did the patient undergo any surgery in the past

☐ Yes ☐ No

If yes, provide the following details:

Name of the Surgery: _____

Name of the hospital where the surgery was performed:

_____

Date on which surgery was performed: D D M M Y Y Y Y

9. Who reported the above mentioned history

10. Treatment given during the course of hospitalization	
11. If discharged condition at the time of discharge	
12. What were the investigation done/advised to be done at the hospital? (if so, please attach copies)	
13. Primary cause of death	
14. Secondary cause of death	

Prior admission details

Had the patient been admitted or treated by you or your hospital earlier?		☐ Yes ☐ No (If yes, provide the following)	
Dates		Reason for seeking treatment	Treatment given
From	To		

Have you attached a copy of Indoor Case Papers & Death / Discharge Summary: ☐ Yes ☐ No

If No, Please provide reason _____

Expense Incurred Details

Details of Fee charged and mode of payment:	Amount:	Mode of Payment:
		☐ Cheque ☐ Cash ☐ DD ☐ Mediclaim ☐ Others If other, please specify _____

If the patient availed the benefit of any Mediclaim insurance policy for the purpose of making payment please provide details	Name of the Insurer	Sum Assured	Amount of claim received	Date of claim

Declaration

We hereby declare that the details furnished in this form are true and correct to the best of our knowledge and belief and is as per the records of the hospital

Doctor's Name & Qualification: _____

Doctor's Signature: _____ Date: _____

Doctor registration no. & contact no.

_____

_____

Address & Seal (to be attested with hospital seal):

_____

_____

Hospital Seal