TREATING DOCTOR'S CERTIFICATE

edelweiss life insurance

Without prejudice

Important points:

- This form needs to be completed by the doctor who has treated the Life Assured in the past and for the last illness suffered
- Please enclose Copies of all medical records of treatment / consultation notes wherever applicable, along with this certificate

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

Name of the Patient / Life Assured: _____ Age:_____

Address: _____

_____ Pin code: _____

Is/Was the Life Assured/Patient related to you? ☐ Yes ☐ No If yes, how: _____

How long have you known the Life Assured: _____

Details of consultation

Date of first / consultation D D M M Y Y Y Y

Was he/she treated as an In-Patient or Out-Patient? _____

Consulted for _____

Consultation during last illness suffered:	
When the ailment was first diagnosed?	
What were the symptoms?	
Was it an acute ailment or complication of some chronic ailment?	
Was it acute-on-chronic presentation of some chronic ailment?	
Duration of complaints:	
What were the investigation undergone by the Life Assured & Where were the test performed?	Investigation done:_____ _____ Name & Address of the Pathology Lab:_____ _____ _____
Treatment given by you?	_____ _____
Was the Life Assured referred from any doctor or hospital?	☐ Yes ☐ No (If yes, Please provide us with the following) Name & Address: _____ _____ Tel. No.: _____
Was the Life Assured referred to any doctor or hospital?	☐ Yes ☐ No (If yes, Please provide us with the following) Name and Address of the referred Doctor/Hospital: _____ _____ Tel. No.:_____
Diagnosis based on tests conducted and evaluation	

Pls provide details of past medical history	**Nature of illness**	**Yes/No**		**Duration**	**Whether last illness treated was a known complication/ sequel of this past medical history?**
	Hypertension	Y	N		
	Diabetes	Y	N		
	Tuberculosis	Y	N		
	Kidney disease	Y	N		
	Liver disease	Y	N		
	Heart disease	Y	N		
	Cancer	Y	N		
	Asthma/COPD	Y	N		
	Others	Please Specify: _____ _____			

Habits & personal history	**Habits**	**Yes/No**		**Duration**	**Quantity consumed**
	Consumption of alcohol	Y	N		
	Smoking	Y	N		
	Tobacco	Y	N		
	Drugs	Y	N		
	Drugs of abuse consumption	Y	N		

Was the insured ever asked to stop the above habit: ☐ Yes ☐ No

If Yes: Pls share the Reason

3. Did the patient undergo any surgery in the past and or now due to the current illness?	☐ Yes ☐ No If yes, provide the following details: Name of the surgery: _____ Indication for Surgery: _____ In case any biopsy done, finding of HP report: _____ Final Diagnosis arrived at: _____ Name of the hospital where the surgery was performed: _____ Date on which surgery was performed: D D M M Y Y Y Y
4. Who reported the above mentioned history	

Whether the Life Assured has availed the benefit of any Medical Insurance policy for the purpose of making payment. If yes, please provide details

In case of death please provide us with the following details

Date of death?	D D M M Y Y Y Y
What was the Immediate cause of death	
Underlying cause of death	

In Case of disability please provide us with the following details

Nature of disability	☐ Permanent ☐ Temporary
Extent of disability	☐ Total ☐ Partial
Cause of Disability	☐ Illness ☐ Accident
If due to illness, please provide the following: Name of the Illness: _____ Date of diagnosis of illness: D D M M Y Y Y Y	If due to Accident, please provide the following: Date of Accident: D D M M Y Y Y Y
Give cause of Injury/Accident:	☐ Self Inflicted; ☐ Road traffic; ☐ Road side; ☐ domestic; ☐ Others; ☐ under influence of Substance Abuse (incl Alcohol) If Others pls specify: _____
If Injury due to substance Abuse /Alcohol Consumption, Test conducted to establish this: If Medicolegal: Reported to Police:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
FIR No :	If not reported to police , give reason: _____ _____
Is the Life Assured capable of performing any occupation or engaging in activities for remuneration or profits?	☐ Yes ☐ No
Name & Address of hospital where the Life Assured was admitted	_____ _____ _____

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