RELIANCE
Life Insurance

Claim Form B - Medical Attendant Certificate by the last treating Doctor

(All answers to be in Block Letters – No Dots and Dashes)

In connection with Claim under Policy No.:

1. Name of the Life Assured:
2. Age of the life assured:
3. Address of the Life Assured:
4. Name and address of the Hospital / Clinic:
5. Are you satisfied regarding the identity of the Life assured as the person whose name and address are furnished above?
   ☐ Yes ☐ No
6. What was the cause of death:
7. Date when diagnosed first:
8. Direct Cause/s of Illness:
9. When did he/she first complain of Illness?
10. What was the nature of complaint?
11. What was the history reported to you at the time of consultation?
12. By whom was it reported? (Mention Name & Relationship to the Patient):
13. How long has he/she been suffering from the illness?
14. Were any tests conducted? If so, mention the tests and findings of the tests:
15. Date and hour of Admission: Admission No.:
16. What was the condition of the patient at the time of Discharge:

Enclosures:

1. Attested copy of Investigation reports / hospital reports (case summary)
2. Discharge Summary
3. Other, if any

The above particulars are furnished on the basis of the records maintained by the Hospital/Clinic.

Date:

Place:

Name of the Doctor:

Designation:

Signature of the attending Doctor

Hospital/ Clinic seal