FUTURE GENERALI INDIA
Life Insurance Company Limited

MEDICAL QUESTIONNAIRE FOR DEATH CLAIM

(To be filled by the physician who last attended the Insured)

Policy Number: ☐☐☐☐☐☐☐☐ **Claim Number:** ☐☐☐☐☐☐☐☐☐☐

Information about the Deceased:

1. Name of the deceased in full :

   First Name: _____ Last Name: _____

   Father/Husband's Name: _____

2. Address of deceased: _____

   _____

3. Age of the deceased: _____Years Gender: Male ☐ Female ☐

Death & Illness Details:

4. Date on which you were **First consulted for current illness**:_____
5. Date on which you have **Last attended for current illness**:_____
6. What was the mode of approach ☐ Himself ☐ Family Relatives ☐Friends ☐ Neighbours
7. Date of Death: _____ Time of Death: _____am ☐ pm ☐
8. Primary Cause of death: _____
9. Antecedent Cause of death:_____ Place of Death: _____
10. First date of diagnosis: _____
11. How long, in your opinion did deceased had been suffering from this disease/condition?_____

    _____

12. While examining the Life Assured, have you seen any past medical records? If Yes, please share details (Attach copies- if available)_____
13. Who certified the cause of death? _____

    If certified by yourself, please attach a copy of the Medical Cause of Death Certificate

Physician's Signature & seal/stamp:

14. Was the Post Mortem conducted? If Yes, please provide details of the hospital_____

_____

15. Any other significant condition / cause contributing to the death: (e.g. Alcohol consumption, Smoking, Drug abuse etc. along with quantity & duration of its consumption) _____

_____

16. Have you treated or given any advise on illness to the deceased during past 5 years prior to last illness? If yes, please provide details? _____

_____

17. Did the deceased, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:

Name of Hospital/Doctor	Date of Consultation	Symptoms/Complaints	Diagnosis/ Tests undergone

18. Any additional information (pertaining to deceased past medical history/Life style) which could help us to process the claim? _____

_____

_____

I hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Physician's Name: Dr._____**Signature & seal/stamp:**

Name & Address of Hospital/Clinic: _____

_____

Registration No: _____ **Tel. /Mob. Number:** _____

Date: _____ **Place:** _____