Medical Attendant's Statement – Form B

Date : ________________

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1) Name of the Life Assured / Patient :________________
2) Address of the Life Assured : ________________
   : ________________
3) Are you a family physician? If yes, How long ? :________________
4) Date of Birth of Life Assured : ________________
5) Nature of illness : ________________
6) Duration of illness : ________________
7) Onset of illness : ________________
8) Date of final Diagnosis : ________________
9) Treatment given : ________________
10) Duration of treatment : ________________
11) Past illness details : ________________
12) Was the Life Assured in habit
    Of consuming tobacco / alcohol : ________________
    If Yes, duration of consumption : ________________
13) Are you aware of the amount
    Of tobacco / alcohol consumed
    Per day by the Life Assured : ________________
    If yes, provide details : ________________
14) Exact cause of death : 1. Primary cause : ________________
    2. Secondary cause : ________________
15) If post-mortem recommended, reason for the same : ________________
    ____
16) Place /date and time of death : ________________
17) Anything hereditary related to the Life Assured you wish to
    disclose that might have affected the longevity in any manner :
    ____

Star Union Dai-ichi Life insurance Co. Ltd.
11th Floor, Raghuleela Arcade, Opposite Vashi Railway Station,
Vashi, Navi Mumbai, Maharashtra : 400703

I, ________________________________, Medical Attendant of the deceased do hereby declare that all the statements given by me are best to my knowledge and in no way hide any information that I had about the deceased Mr. / Mrs. / Ms.____ and the cause of death do not give any type of suspicion indicating that the deceased died out of his / her own act.

Place : ________________________

Date : _________________________ ______________________________

Witness to Medical Attendants : Signature of Medical Attendant

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Seal of the Clinic / Hospital

Identity and signature of Witness

Name of witness : ___________________________

Address of witness : _________________________

Contact No. : _______________________________

Name of Medical Attendant :_______________________

Address of Medical Attendant : _________________________

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Contact No. : _______________________________________

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