



STAR UNION DAI-ICHI LIFE INSURANCE CO. LTD.

Medical Treatment Certificate from Hospital – Form C

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- 1) Name of the Life Assured : \_\_\_\_\_
  - 2) Address of the Life Assured : \_\_\_\_\_  
: \_\_\_\_\_
  - 3) Date of Birth of Life Assured : \_\_\_\_\_
  - 4) Complaint reported by deceased : \_\_\_\_\_
  - 5) Whether reported in discharge card : \_\_\_\_\_
  - 6) History of illness reported by patient: \_\_\_\_\_
  - 7) On-set of above illness : \_\_\_\_\_
  - 8) Treatment given here : \_\_\_\_\_
  - 9) Duration of treatment given : \_\_\_\_\_
  - 10) Was the Life Assured in habit  
Of consuming tobacco / alcohol : \_\_\_\_\_
  - 11) Was the Life Assured ever got  
Admitted before in your hospital: \_\_\_\_\_
  - 12) If Yes, Admitted for illness : \_\_\_\_\_
  - 13) Previously treated : from \_\_\_\_\_ to \_\_\_\_\_
  - 14) Name of the physician who  
Treated the Life Assured : \_\_\_\_\_
  - 15) Diagnosis of the physician on  
the discharge card : \_\_\_\_\_
  - 16) Date of admission & discharge : \_\_\_\_\_ , \_\_\_\_\_
  - 17) Incase of death, Date of death : \_\_\_\_\_
  - 18) Place and Time of death : \_\_\_\_\_ am / pm
  - 19) Any detail your hospital wish to share with regards to health of Life Assured :  
\_\_\_\_\_

Place : \_\_\_\_\_

Date : \_\_\_\_\_

Name of hospital : \_\_\_\_\_

Address of hospital : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sign / Stamp / Seal of hospital