Pramerica | LIFE INSURANCE

Last Medical Attendant's Report

(This form should be filled by a qualified and registered Medical Practitioner who is other than Policyholder, Life Insured or the Relative

Policy No. ____________________

Date: D D M M Y Y Y Y

Personal Details of the Lfe Insured

Name: ____________________

Address: ____________________

____

Apparent Age at the Time of Death: ____________________

Details Relating to Death

Date of Admission: ____________________

Date & Time of Death: ____________________

Place of Death (Address): ____________________

____

Was Post-Mortem Performed on the Life Assured? Yes/No	If yes, Name and Address of the Hospital where the Post Mortem was performed:

Primary Cause of Death: ____________________

Secondary Cause of Death: ____________________

Symptoms prior to Death: ____________________

Symptoms Duration prior to Death: ____________________

Were these causes ascertained by examination after death or from the symptoms and appearances during Life?

____

Details of History Reported at the Time of Death

Name, Address & Telephone No. of Referring Doctor: ____________________

____

Doctor MCI Registration number: ____________________

Date of First Consultation: ____________________

Date of First Admission in Hospital: ____________________

History recorded at the time of Consultion/Admission:

Name of Illness/Complaints	Since when? (Date & Time)

History was given By	Life Insured/Others. If Others: Name: ____________________ Age: ☐☐☐ Sex: ☐ Male ☐ Female Relationship with the Insured: ____________________
History was Recorded By	Name: ____________________ Designation: ____________________

Policy No: ☐☐☐☐☐☐☐☐☐

Investigations Conducted

Was any Investigation conducted on the Life Insured:

Type of Investigation Conducted	Results/Readings

Diagnosis made after investigation - Name of Illness/Diseases: ____________________

____

Name, Qualifications & Address of the Doctor by who the above Diagnosis were made:

____

____

Treatments Given: ____________________

____

Name, Qualifiactions, Address, Telephone No. of Life Insured usual Medical Consultant/Family Doctor:

____

____

Had the Life Insured been ever admitted on earlier occasion to this hospital or had the Medical Attendant treated him/her earlier? If yes, please fill the following details

As In-Patient	As Out-Patient	Dates		Complaints/ Symptoms	Treatment Given	Name, Address & Telephone of the Treating Doctor
		From	To			

Habits of the Life Insured

a) Were the Life Insured's habits Sober & Temperate? Yes ☐ No ☐

b) Did he have any addiction such as Smoking, Drinking etc.? Yes ☐ No ☐

If Yes, Please provide details about the quantity consumed: ____________________

____

c) Have you any reason to suppose or to suspect that the disease was in this case caused or aggravated by intemperate habits? ____________________

____

(7a.) When & for which other disease/ailment/illness did you treat the Life Insured in the last 3 years before this? ____________________

(7b). Any other information, which you consider would be useful for processing the claim under the Policy. ____________________

Declaration:

I have personally attended to the Life Insured and that the above information is true and accurate to the best of my belief and knowledge.

Signature of the Medical Attendant ____________________ Date: D D M M Y Y Y Y

Name & Registration No. ____________________

Stamp & Address ____________________ Place: ____________________

LMAR/QUES-ENG/DEC/19/V5

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