

## **Attending Physician's Statement – Critical Illness**

Note: PLEASE SIGN ON ALL PAGES BOTTOM.

| DOCTOR'S DETAILS:              |  |          |
|--------------------------------|--|----------|
| Name of the Attending Physic   | cian:  |          |
| Name of the clinic / Hospital  |  |          |
| Traine of the chine / Hospital | ·  |          |
| Address:                       |  |          |
| Contact No.                    | E-mail address :   |          |
| CLAIMANT/PATIENT'S I           | DETAILS:   |          |
| Name of the Claimant :         |  |          |
| Address:                       |  |          |
| Age & Sex:                     | Hospital/Indoor Patient Number:                              |          |
|                                |  |          |
| SPECIFY WHICH CRITIC           | CAL ILLNESS IS APPLICABLE:                                   |          |
|                                |  |          |
| HISTORY                        |  | <u> </u> |
| HISTORI                        |  |          |
| Date of appearance of first sy | /mptoms:   |          |
| Has the patient ever had the s | same or similar condition in past : Yes No                   |          |
| (If "ves." state when and pro  | ovide details. Kindly attach another sheet if required)      |          |
| (3 ),                          |  |          |
|                                |  |          |
|                                |  |          |
| -                              | T CONDITION:   |          |
| Subjective symptoms:           | <del></del>  |          |
| Objective findings (include i  | results of current X-rays, ECGs or any other special tests): |          |
|                                |  |          |
|                                |  |          |
|                                |  |          |

Star Union Dai-ichi Life Insurance Company Limited

Registered Office: 11th Floor, Vishwaroop IT Park, Plot No. 34, 35 & 38, Sector 30A of IIP, Vashi, Navi Mumbai – 400 703.

Toll Free No.: 1800 266 8833 (9:00 am to 7:00 pm – Mon to Sat)

Email: customercare@sudlife.in | Website: www.sudlife.in | IRDAI Regn. No. 142 | CIN: U66010MH2007PLC174472

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## **DIAGNOSIS:**

| Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:   | Discourance in describe   |     |    |
|--|---|-----|----|
| Date of first Visit: OP Number / Hospital No / Indoor Patient No Date of last Visit: Frequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Prequency of visits(Weekly/mont | Please provide details:   |     |    |
| Date of first Visit: OP Number / Hospital No / Indoor Patient No Date of last Visit: Frequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Prequency of visits(Weekly/mont |   |     |    |
| Date of first Visit: OP Number / Hospital No / Indoor Patient No Date of last Visit: Frequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Date of last examination: Prequency of visits(Weekly/monthly/other): Prequency of visits(Weekly/mont | Treatment:  |     |    |
| OP Number / Hospital No / Indoor Patient No  |   |     |    |
| OP Number / Hospital No / Indoor Patient No  | Date of first Visit:  |     |    |
| Date of last Visit:  |   |     |    |
| Date of last examination:  |   |     |    |
| ROGRESS:  Recovered Improved Unimproved Retrogressed  IENTAL CONDITION:  Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  these statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:   |   |     |    |
| Recovered Improved Unimproved Retrogressed  IENTAL CONDITION:  Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  | Date of last examination:   |     |    |
| Recovered Improved Unimproved Retrogressed  IENTAL CONDITION:  Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  |   |     |    |
| Recovered Improved Unimproved Retrogressed  IENTAL CONDITION:  Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  |   |     |    |
| IENTAL CONDITION:  Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:   | PROGRESS:   |     |    |
| Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:   | Recovered Improved Unimproved Retrogressed  |     |    |
| Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No  ECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:   |   |     |    |
| bECLARATION:  hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  | MENTAL CONDITION:   |     |    |
| hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  | Is the patient competent to endorse checks and direct the use of proceeds there of? | Yes | No |
| hese statements are true and complete to the best of my knowledge and belief.  ame & Signature of the Physician:  ate:  ualification:  |   |     |    |
| ame & Signature of the Physician: ate: ualification:   | DECLARATION:  |     |    |
| ate:ualification:  | hese statements are true and complete to the best of my knowledge and belief.       |     |    |
| ualification:  | ame & Signature of the Physician:   |     |    |
|  | ate:  |     |    |
|  |   |     |    |
| eg. No:( Seal)   |   | a1) |    |

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