



PHS000101

**Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.**  
 Unitech Trade Centre, 2nd Floor, Sushant Lok, Phase-1, Sector-43, Gurgaon, Haryana, India – 122009

### Physician's Statement

Form – P

**Important Information:**

1. A separate Form P is to be filled up by each of the following medical practitioners : (1)Family /Usual doctor/Any doctor in the vicinity, (2)All Doctors who attended the deceased in the last illness and (3)All doctors who have attended the insured in the past
2. A qualified registered practitioner should fill in this form
3. Please attach medical records of the treatment/ consultation taken by the deceased

**Policy no(s)** \_\_\_\_\_

**PART-I**

- i. Name and Address of the deceased \_\_\_\_\_
- ii. Age at Death   years      Occupation \_\_\_\_\_
- iii. Was the deceased related to you? Yes  No       If yes, how? \_\_\_\_\_
- iv. How long did you know the deceased life assured? \_\_\_\_\_

**PART-II**

- i. Date and Time of Death / /  :  (a.m.  / p.m. ) ,Place of Death \_\_\_\_\_

**PART-III**

- i. What was the immediate cause of death of the deceased? \_\_\_\_\_
- ii. How long did the deceased life assured suffer from this illness? \_\_\_\_\_
- iii. When did the deceased first consult you during his last illness? \_\_\_\_\_
- iv. What were the symptoms/ complaints of the deceased at the time of consultation?  
\_\_\_\_\_
- v. What were the investigations undergone by the deceased to confirm the cause of death? (Please attach separate sheets if required) \_\_\_\_\_
- vi. When the diagnosis was finally confirmed? \_\_\_\_\_
- vii. What was the treatment given to the deceased during the last illness or earlier? \_\_\_\_\_
- viii. Did you treat the deceased during the whole course of the illness? Yes  No   
If No, then what was the period of consultation? / /  to / /
- ix. Did you refer the deceased to any other medical practitioner/ hospital for further treatment?  
Yes  No   
If yes, provide with the name and Address \_\_\_\_\_ Tel: \_\_\_\_\_
- x. Was/ were there any other contributory illnesses/ chronic ailments suffered by the deceased that led to the death? Yes  No   
If yes, detail \_\_\_\_\_
- xi. Were you the usual doctor of the deceased? Yes  No   
(a) If no, provide the name of the usual doctor \_\_\_\_\_  
(b) If yes, then
  - For how long \_\_\_\_\_
  - Date of consultation (s) \_\_\_\_\_
  - Diagnosis \_\_\_\_\_
  - What was the treatment given \_\_\_\_\_



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xii. Did the deceased suffer from any other illness that led to the death? Yes  No

If yes, provide the details \_\_\_\_\_

\_\_\_\_\_

xiii. Did you have reason to believe that the cause of death was due to the deceased's own actions (eg self inflicted injury) Yes  No  , if yes please provide details \_\_\_\_\_

xiv. Was any Inquest or formal Inquiry held regarding the death or was a Post Mortem Examination of the body made? Yes  No

If yes, by whom and what was the result or finding? \_\_\_\_\_

\_\_\_\_\_

xv. Did the life assured have any adverse habits? Yes  No

If yes, please detail \_\_\_\_\_ Did these adverse habits led to the disease?  
(State reasons) \_\_\_\_\_

xvi. Please provide the details of the medical practitioners who had attended the deceased during the last 5 years

Name	Address	Contact No.

xvii. Please provide any additional relevant information/remarks that would help us in evaluation of this claim (deceased's habits, ailments etc) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I \_\_\_\_\_, Medical Attendant of the deceased \_\_\_\_\_ do hereby solemnly declare that the above statements are true and correct to the best of my knowledge and belief.

Place \_\_\_\_\_ Date / /

Signature of Medical Attendant: \_\_\_\_\_

Name of Medical Attendant: \_\_\_\_\_

Stamp of Medical Attendant: \_\_\_\_\_

Registration number: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number \_\_\_\_\_