



PHS000101

**Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.**

139 P, Sector 44, Gurugram – 122003, Haryana (India)

**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 _____