PHS000101

Canara HSBC
LIFE INSURANCE

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 _____

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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?

If yes, by whom and what was the result or finding? Yes No

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 _____