



THC000101



Life Insurance

Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.
2nd Floor, Orchid Business Park, Sector - 48, Sohna Road, Gurugram, Haryana, India – 122018

Treating Hospital Certificate

Form – H

Important Information:

- 1. This form is to be completed by the authorities at all the hospitals where the deceased was hospitalized
2. Please attach the patient admission sheet, investigations, history sheet, treatment records along with this form
3. One form is to be filled up per hospital/ nursing home

Please provide the following information based on the medical records and annex supporting documents

Policy no(s) _____

Form containing 10 sections (i-x) for providing medical details: i. Name and Address of the deceased, ii. Age at Death, Occupation, Any mark of identification?, iii. Date of Death, Time of Death, Place of Death, iv. Date and Time of admission, Admission no., v. Was the deceased referred by any doctor/ hospital, vi. Name of the doctor who had recorded the history, vii. Did the deceased suffer from any past ailment, viii. What was the diagnosis made at the hospital, ix. What were the tests/ investigations undergone by the deceased, x. When was the diagnosis confirmed at the hospital?



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xi. What was the treatment given to the deceased during the hospitalization?

Two horizontal lines for text entry.

xii. Was/ were there any other contributory illnesses/ chronic ailments suffered by the deceased that existed at the time of admission? Yes No

If yes, detail

Two horizontal lines for text entry.

xiii. What was the date of discharge from the hospital? / /

xiv. What was the condition of the deceased at the time discharge?

Two horizontal lines for text entry.

xv. Was the deceased treated at the hospital at any other occasion as an out-patient or inpatient? Yes No

If yes, please provide details

Two horizontal lines for text entry.

xvi. Was the deceased treated by any other medical practitioner/hospital during the past 3 years? Yes No

If yes then provide the details:

Table with 3 columns: Name, Address, Contact No. and 3 empty rows.

Certified that the above information is correct as per hospital records:

Date: / / Place

Signature: _____

Name and Designation of the Doctor:

Qualifications and code of the Doctor:

Name of the Hospital:

Registration Number of the Hospital:

Address:

Telephone Number

Seal / Stamp of the Hospital: _____

(Mandatory)