Form No 3816
Claim Form B1

भारतीय जीवन बीमा निगम
Life Insurance Corporation of India
Central Office, Mumbai

Br.No :

CERTIFICATE OF HOSPITAL TREATMENT

In connection with the claim under Policy No. on the life of

(insert full name of deceased)

1. What was the full name, age, address and occupation of the patient as per Hospital Records ? Name : Age : Addr1: Addr2: Addr3: Pin Occupation : Identification Marks :	
2. What was the date of his admission into the Hospital ? Please state his indoor admission No.	
3. Under whose treatment was the patient before he was admitted to the hospital ? If the patient had brought a letter or a note from any Doctor at the time of admission kindly furnish us with a certified copy thereof.	
4. What at the time of admission was a. the nature of his complaint b. the duration of the complaint as reported by him ?	a) b)
5. a. What was the exact history reported by the patient at the time of his admission? (Full history including the dates, duration of the ailments, the symptoms narrated etc. to be given).	
b.i) Was the history reported by the patient himself/herself ? ii) If not, by whom ? (Name and relationship of the person who reported it). Was the patient present at that time and was he/she conscious?	
c. Who recorded the history in the case sheet ?	
d. Whether the Doctor who recorded the history is still in your service if not please state his/her full address. **Note:** Properly certified copy of the full history may please be furnished.	

6. What was the diagnosis arrived at in the Hospital?	
7. Was there any other disease or illness preceded or coexisted with the ailment at the time of his /her admission into the hospital? If so what was it? Please give history of such disease or illness stating a. History Reported ? b. Date when such was first observed by patient. c. By whom treated? d. By whom the history was reported (if not by the patient himself/herself please indicate if it was in his/her presence and to his/her knowledge). e. Who recorded the history? (If the Doctor is not with the hospital at present, please give his/her present address).	
8. What was the date of his/her discharge from Hospital?	
9. What was his/her condition when he/she was discharged?	
10. Was he/she treated in the Hospital on any previous occasion either as an in-patient or an outpatient? If so, please state : a. Date of first admission or first time treatment as an outpatient. b. Date of discharge and condition on discharge. c. Nature of ailment. d. History reported at the time of admission.	

Certified that the above information is correct as per records of the Hospital.

Date Signature Code No

Qualification and Designation

Name of Hospital Postal Address :

Pin

(State here the Code No. if you are an authorized Medical Examiner of the Corporation).