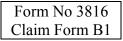


भारतीय जीवन खीमा निगम Life Insurance Corporation of India Central Office, Mumbai



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	fhis admission into	
the Hospital ?	of this admission into	
Please state his indo	or admission No	
3. Under whose treat		
before he was admit		
	ought a letter or a note	
-	the time of admission	
	with a certified copy	
thereof.		
4. What at the time of	admission was	
a. the nature of	his complaint	a)
b the duration	of the complaint as	1
reported by l	-	b)
5. a. What was the ex-		
	time of his admission?	
(Full history i	ncluding the dates,	
duration of the ailments, the symptoms		
narrated etc. to be	e given).	
· · · · · · · · · · · · · · · · · · ·	story reported by the	
patient himself/		
	whom ? (Name and	
1	f the person who	
	as the patient present	
at that time and was he/she conscious?		
	history in the case	
c. Who recorded the history in the case sheet ?		
	ctor who recorded the	
history is still in your service if not		
please state his/he	-	
Note: Properly certified co		
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.	
c. mature of animent.	
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).