



**SHRIRAM LIFE INSURANCE COMPANY LIMITED**

**CLAIM FORM "B"**

**Divisional Office** .....

**Branch Office** .....

**MEDICAL ATTENDANT'S CERTIFICATE**

(To be completed by the Medical Attendant of the Deceased in his last illness)

In connection with Claim under Policy No .....

On the life of .....

(Insert full name of the deceased)

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| <p>1. What was the full name, address and occupation of deceased?</p>  | <p>Name :<br/>Address:<br/><br/>Occupation:</p>                          |
| <p>2. (A) What as nearly as you could judge was the age of deceased at death?</p> <p>(B) Was he related to you and if so, how?</p> <p>(C) Please describe any marks or physical peculiarities noticeable for the purpose of identification?</p>  | <p>(a) Apparent Age                      Years</p> <p>(b)</p> <p>(c)</p> |
| <p>3. What was the time and date of his death</p>  | <p>At            o'clock A.M/P.M<br/>On the .....day of.....20</p>       |
| <p>4. Where did he/she die(Give exact address)</p>   |  |
| <p>5. (A) What was the exact cause of death?<br/>(Besides defining the disease or other cause of death in such terms as you consider appropriate, [Kindly add the distinctive technical name.])</p> <p>(B) Was it ascertained by examination after death or inferred from symptoms and appearance during life?</p> | <p>(a) Primary cause<br/><br/>Secondary cause</p> <p>(b)</p>             |

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|--|--------------------------------------|
| (C) How long had he/she been suffering from this decease before his/her death?   | (c)                                  |
| (D) What were the symptoms of the illness?   | (d)                                  |
| (E) When were they first observed by the deceased?   | (e)                                  |
| (F) What was the date on which you were first consulted during the illness?  | (f)                                  |
| (G) Did you attend him/her during the whole of its course? If not, state during what period?   | (g)                                  |
| 6. (A) Were his/her habits sober & temperate?  | (a)                                  |
| (B) Have you any reason to suppose or to suspect that disease was in his case caused or aggravated by intemperate habits?  | (b)                                  |
| 7. What other disease or illness<br>(i) preceded or<br>(ii) co-existed with that which immediately caused his/her death?<br><br>Give history of such disease or illness stating:-<br>(a) Date when first observed?<br>(b) By whom treated?<br>(c) By whom history reported to you?   | (i)<br>(ii)<br><br>(a)<br>(b)<br>(c) |
| 8. (A) Was the deceased treated during his/her last illness by any other Medical practitioners or in any Hospital before you were consulted? If so, please state their names & addresses<br><br>(B) Did any other Medical Practitioners attend to him/her in consultation with yourself? If so, please state their names & addresses | (a)<br><br>(b)                       |
| 9. (A) Were you the deceased's usual Medical Attendant?<br>(B) If so, for how long?<br>(C) If not, please state name address of his/her usual Medical Attendant?   | (a)<br>(b)<br>(c)                    |

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|---|--|
| 10. When and for what ailments did you treat the deceased during the three years preceding his/her last illness?  |  |
| 11. Was any Inquest or formal Inquiry held regarding the death or was a post – Mortem Examination of the body made?<br><br>If so, by whom, and what was the result or findings? |  |
| 12. Have you any other information or remarks to make in connection with this claim concerning deceased's ailments, habits, mode of living etc..?                               |  |

I ..... Medical Attendant of the deceased ..... DO HEREBY SOLEMNLY DECLARE that the foregoing statements are true and correct to the best of my knowledge and belief, and that the deceased did not die by his own act.

Dated at ..... this ..... day of ..... 200

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

**WITNESS**

Name .....  
Signature .....  
Occupation .....  
Qualifications .....  
Postal Address .....  
.....  
.....

Signature of Medical Attendant  
**And**  
Postal Address .....  
.....  
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