**SuryaJyoti Life Insurance Company Limited**
**Head Office - Shanta Plaza, Gyaneshwor, Kathmandu Nepal**
**Tel 4545947/48/50, P.O. Box No. 19433, Email: info@suryajyoti.com**



# MEDICAL ATTENDENT'S CERTIFICATE

(This form is to be completed by the treating medical attendant of the insured in his/her last illness)

- Please attach separate sheets if required.
- This form should be filled in on the basis of the information available from the records maintained by the doctor.

Policy Number : .....

1) Full name, address & occupation of the deceased:
   a) Name : _____
   b) Address : _____
   c) Occupation : _____

2) a) Age of Life Assured at the time of death : _____years
   b) Was he/she related to you? If so, how? : _____
   c) How long had you know the deceased? : _____

3) a) Time of death : _____am/pm
   b) Place of death : _____

4) a) What was the immediate cause of death? : _____
   b) Was there any contributory cause of death or any antecedent aliments : If yes, please give details_____
   c) What were the exact complaints/symptoms? : _____
   d) How long had he/she been suffering from this disease before death? : _____
   e) What was the date on which you were first consulted for the illness? : _____
   f) What was the date of last consultation/follow up? : _____

5) Was the deceased treated by any other medical practitioner or in any hospital before you were consulted? If yes please give : Name: _____ Address: _____

6) Were you the deceased's usual doctor? : _____
   If yes, please state:
   a) For how long : _____
   b) Date(s) of consultation : _____
   c) Treatment given : _____

| | | |
|---|---|---|
| 7) | Since when was the deceased under any kind of medical care? What were the complaints? | Date: _____<br>Details: _____<br>_____ |
| 8) | Please give details of treatment rendered in the past and of last illness | : _____<br>_____ |
| 9) | Please provide details of the investigations conducted and tests undergone so as to confirm the diagnosis (attach separate sheets if required.) | : _____<br>_____ |
| 10) | a) When was the final diagnosis made? | Date: _____ |
| | b) Since when did the deceased suffer from ailment? | : _____ |
| 11) | Did the deceased suffer from any antecedent illness? If yes, please give the details (attach separate sheets if required.) | Date: _____<br>_____<br>_____ |
| 12) | Was any Post Mortem conducted? If yes, please give the cause of death as per Post Mortem report | : _____<br>_____<br>_____ |
| 13) | Have you any other information to be shared with in connection with this claim concerning deceased's, habits etc. | : _____<br>_____ |

I, Dr.……MedicalAttendant of the deceased …… Do Hearby Solemnly Declare that the foregoing statements are True and Correct to the best of my knowledge and belief and the deceased did not die by his own act.

Signature:

Name: …….  NMC No.: …….

Date: ……

Address: ……  Stamp: