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

ATTENDING PHYSICIAN'S STATEMENT FOR CRITICAL ILLNESS

(A qualified and registered medical practitioner who had attended the Life Assured during the period of his/her Critical illness should complete this form. A Policyholder or Life Insured who is himself/herself a medical practitioner as also the spouse or near relative of a Policyholder/Life assured and who is a medical practitioner is not allowed to fill up this form)

PART I - GENERAL INFORMATION

1) Name of the patient : _____

2) a) Date of Birth : D D M M Y Y Y Y b) Age: _____

3) Are you the patient's usual doctor? If "yes", please give the following details.

a) Since when have you known the patient : _____ Years

b) Is the patient related to you? If yes, how? : _____

c) Dates of consultation : D D M M Y Y Y Y

d) Final Diagnose date : D D M M Y Y Y Y

4) Was the patient referred to you by another doctor or hospital? If "Yes", please state:

a) Name of doctor/hospital : _____

b) Address & contact number of doctor/hospital : _____

PART II - Details of the illness complained

5) Please fully describe the nature of illness and the diagnosis - (Please attach original reports where applicable).

a) Date and details of first symptoms : D D M M Y Y Y Y

b) Details of past history and date of first symptom : _____

c) Investigations done/advised to be done/ laboratory tests undergone : _____

d) Details of Treatment Given: Medical/surgical/ Hospitalization/Conservative : _____

e) Final Diagnosis (please include any specialist/ lab reports) : _____

f) If surgery performed, please describe fully the date on which it was performed and the nature of the surgery : _____

g) Describe any other disease or infirmity affecting present condition : _____

6) Follow up Details

a) When was the date of last attendance at the hospital: D D M M Y Y Y Y

b) Is the patients till under your care for this condition? If so, please give details. : _____

c) Any additional information you would prefer to share : _____

7) Was the patient referred to any other doctor or medical facility by you? If yes, please provide details.

Name of doctor/hospital : _____

Address & contact number of doctor/hospital : _____

8) a) In case of hospitalization, please give name and address of hospital : _____

b) Date admitted : | D | D | M | M | Y | Y | Y | Y |

c) Date discharged : | D | D | M | M | Y | Y | Y | Y |

9) What is the prognosis? : _____

10) Please provide us with any other additional information including neurological examinations, laboratory tests, X-ray etc that will enable the company to assess this claim

11) Any other information, which in your opinion will assist us in assessing this claim : _____

I hereby certify that I have personally examined and treated the patient for the above illness and that the details as given above are based on records and the opinions expressed are based on my assessment of the facts.

Name of physician : _____

Medical Council Registration No. : _____

Signature : _____

Date (With stamp) : | D | D | M | M | Y | Y | Y | Y |

Qualification : _____

Address : _____

Telephone No. : _____