

Policy No.:
Claim No.:

Tata AIA Life Insurance Company Limited
(hereinafter called "Tata AIA" or "the Company", whichever is applicable)

CERTIFICATE OF MEDICAL ATTENDANT

To be completed in **BLOCK** letters by a duly qualified and registered medical practitioner at the claimant's expense. Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.

Patient Name	Age	Sex
Patient's Occupation	I. D. No.	
Patient's Address	I. D. Document Type	

Consultation Details

If due to ILLNESS , please provide:	If due to ACCIDENT , please provide:
Chief complaints & presenting symptoms	Conditions of injury & parts of body involved
	Is there external visible evidence of injury at your first consultation: If yes, give details
Date symptoms first appeared	Date of injury
Your Diagnosis	Cause of injury
Date of your consultation of this illness/injury	
First consultation on	Last consultation on
Past medical history, family history and co-morbid conditions (please give consultation dates & details)	

Hospitalization Details

Does this illness/injury necessitate inpatient hospitalization: <input type="checkbox"/> No <input type="checkbox"/> Yes, details as below:-	
Hospital Name	Date & Time of Admission
Address	Date & Time of Discharge
Any surgical procedure performed? <input type="checkbox"/> No <input type="checkbox"/> Yes, details as below:-	
Date of operation	Place of operations
Name of surgical procedure	Surgeon Name & Registration No.
Tests & investigations performed? <input type="checkbox"/> No <input type="checkbox"/> Yes, details as below:-	
<u>Name of test/investigations</u>	<u>Date(s)</u> <u>Results</u> (please enclose a certified true copy of the test results)
Other treatments administered (medicines, dressing & suturing etc)	
Discharge summary & treatment plan	
Dates of follow-up consultations with you after hospital discharge for the same illness/injury	
<u>Date(s)</u>	<u>Condition</u>

CLM/P4.9/4.T3 (II) - 29May2003

Was healing complicated?	<input type="checkbox"/> No <input type="checkbox"/> Yes, details as below:-	
If yes, state reasons and any special treatment given.		
Bearing in mind the patient's occupation, do you feel the illness/injury would have prevented him/her from working at your first consultation at your last consultation	<input type="checkbox"/> No	<input type="checkbox"/> Yes, details: _____ No Yes, details: _____
If absence from work more than 2 weeks was necessary, please state the reasons.		
Is the illness/injury related to		
(a) Physical defects/congenital anomaly	<input type="checkbox"/> No <input type="checkbox"/> Yes,	details: _____
(b) Unfavourable past medical history	<input type="checkbox"/> No <input type="checkbox"/> Yes,	details: _____
(c) Degenerative changes	<input type="checkbox"/> No <input type="checkbox"/> Yes,	details: _____
(d) Alcohol, drug, or nicotine/smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes,	details: _____
(e) AIDS or HIV infection	<input type="checkbox"/> No <input type="checkbox"/> Yes, details: _____	
(f) Suicide or self-inflicted injury	<input type="checkbox"/> No <input type="checkbox"/> Yes, details: _____	
Other doctors/hospitals involved in the care of the patient		
Name	Address	Telephone No.

Declaration by the Attending Physician/Specialist	
I declare that the answers given are true and complete.	
I declare I am duly licensed and registered to practice western medicine (allopathy) in India (if outside India, please state where _____)	
Certification by Hospital Admitted, that	
1) The Hospital is duly licensed and registered as a Hospital to provide treatment in western medicine (allopathy) in India (if outside India, state where _____) for the care and treatment of sick and injured persons as registered in-patients, fully equipped with facilities for diagnosis and major surgery which are under the constant supervision of one or more Registered Medical Practitioners, and which have 24-hour a day full time professional nursing services; And	
2) Maintains proper medical and patient records and quality health care to the standards as required under the prevailing laws and regulations in the geographical area it is located; And	
3) Is not an institution operated as a convalescent or rest home, a hotel, a home for the aged, a place for alcoholics or drug addicts, or Custodial Care, or for any similar purpose.	
4) The Hospital has on the following facility and resource (please state)	
No. of in-patient beds : _____	
No. of qualified registered resident doctors: _____	
No. of qualified registered full time nurses : _____	
_____ Signature of Attending Physician/Specialist (with qualifications)	_____ Signature of authorized Hospital Administrator
[Name in Block: _____]	[Name in Block: _____]
_____ Registration No. & Place	_____ Name of Hospital
_____ Address & Official Stamp	_____ Registration No. & Place
_____ Telephone	_____ Address & Official Stamp
_____ Mobile No.	_____ Telephone Fax No.
_____ Email Address	_____ Email Address
_____ Date	_____ Date

Hospital Information Sheet

Please provide your answers in the right column and return it to us at the following address for our database:

Tata AIA Life Insurance Co. Ltd.
 B- wing, 9th Floor, I-Think Techno Campus, Behind TCS, Pokhran Road No.2,
 Close to Eastern Express Highway, Thane (West) Pin Code – 400 607.
 Attn: Claims Department

<ul style="list-style-type: none"> ▪ Name of hospital : ▪ Registration no. & Registering authority & Place : ▪ Address : ▪ Tel. No. : ▪ Fax no. : ▪ Web site : 	
<ul style="list-style-type: none"> ▪ Name of contact person : ▪ Designation : ▪ Telephone no. : ▪ Email address : ▪ Name of Owner (if different from contact person above) : 	
The Hospital provide treatment in (tick as appropriate) :	<input type="checkbox"/> western medicines (allopathy) <input type="checkbox"/> alternate medicines (state details) _____
Specialties available (e.g. Paediatrics, Orthopaedics, ENT etc) If yes, please state details:	
<ul style="list-style-type: none"> ▪ No. of in-patient beds: 	
<ul style="list-style-type: none"> ▪ No. of qualified registered resident doctors : For government hospitals, please also state <ul style="list-style-type: none"> ▪ No. of Professor doctors: ▪ No. of Assistant Professor doctors: ▪ No. of Lecturer doctors: 	
<ul style="list-style-type: none"> ▪ No. of qualified registered full time nurses : 	
<ul style="list-style-type: none"> ▪ In House facility available [please state Yes in the right column if available] 	
<ul style="list-style-type: none"> ▪ Pathology Lab. : 	
<ul style="list-style-type: none"> ▪ Oxygen : <li style="padding-left: 20px;">- Central supply : <li style="padding-left: 20px;">- Cylinder : 	
<ul style="list-style-type: none"> ▪ E. C. G. : 	
<ul style="list-style-type: none"> ▪ X Ray : ▪ Ultrasonography : ▪ C. T. Scan : ▪ M. R. I. Scan : 	

▪ Pathology :	
▪ Blood Bank :	
▪ Operation Theatre :	
▪ Labour room / delivery room :	
▪ I. C. C. U.:	
▪ Cardiac monitor :	
▪ Defibrillator :	
▪ Ventilator :	
▪ Emergency Room :	
▪ Day Care Centre :	
▪ Outpatient consultation :	
▪ Computerized access to patient records :	
▪ Other facilities – please state details :	

The above information is certified to be true and complete.

Signature of Hospital Administrator

Date

[Name in Block:]

Hospital Name & Official Stamp