GENERALI Central
LIFE INSURANCE

MEDICAL QUESTIONNAIRE FOR DEATH CLAIM

(To be filled by the physician who last attended the Insured)

POLICY DETAILS

Policy number: | | | | | | | | |

DETAILS OF THE LIFE ASSURED

Name of Life Assured: ☐ Mr. ☐ Ms. ☐ Mrs. _____

Father's / Husband's name: _____

Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender

DETAILS OF CURRENT ILLNESS

Symptoms / complaints: _____

Duration of symptom / complaint: _____

First consultation for current illness: D D M M Y Y Y Y

Last consultation for current illness: D D M M Y Y Y Y

Diagnosis: _____

PAST MEDICAL HISTORY

Have you treated or given any advice on illness to the deceased, prior to last illness? ☐ YES ☐ NO If yes, please provide details:

DESCRIPTION	DATE	DURATION OF ILLNESS	DETAILS (DIAGNOSIS, TREATMENT)
1. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		
2. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		
3. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		

Did the deceased, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? ☐ YES ☐ NO
If yes, please provide details:

NAME OF HOSPITAL / DOCTOR	CONTACT DETAILS	DATE OF CONSULTATION	SYMPTOMS / COMPLAINTS	DIAGNOSIS / TESTS UNDERGONE
		D D M M Y Y Y Y		
		D D M M Y Y Y Y		

DETAILS OF DEATH

Date of death: D D M M Y Y Y Y Immediate and underlying cause of death _____

Who certified the cause of death? ☐ Certified by me, ☐ Certified by someone else

If certified by yourself, please attach a copy of the Medical Cause of Death Certificate / Declaration on Letterhead

Any other significant condition/cause contributing to the death: ☐ Alcohol consumption, ☐ Smoking, ☐ Drug abuse, ☐ Tobacco, ☐ None.

If any, duration of consumption……& quantity consumed……

DECLARATION

I hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Physician's name: _____ Registration no.: _____

Name & address of hospital / clinic: _____

_____ PIN Code: | | | | | | | Mobile / Telephone number: | | | | | | | | | | |

Date: D D M M Y Y Y Y

Sign here
Signature

Seal / stamp here
Seal / stamp:

Place: _____

Note: If you feel that the space provided is insufficient anywhere, kindly attach additional sheets