Max Life Insurance Co.Ltd.
90 A, Sector-18, Udyog Vihar, Gurgaon-122015, Haryana
Phone Number- 0124-4219090- Extn- 9699, Toll Free- 18002005577
Email- claims.support@maxlifeinsurance.com

Attending Physicians Statement- Form TC

(A qualified and registered medical practitioner should complete this form. Policy Holder, Life Insured who are also medical practitioners or their Spouse, or Lineal Relative of Policy Holder/Life assured cannot fill it)

I. General Information

1 a) Name of the Patient………………………………………….. b) Age……………………

2. Are you the patient's usual doctor? If "yes", please give details. How long have you known the Patient?…………

Date of consultation……………… Diagnosis…………………………Treatment given……………………………

3. Was the patient referred to you by another doctor or hospital? If "Yes", please give details:

Name of doctor/ hospital……………………………….Address of doctor/hospital……………………………………

II. Information about the Terminal Illness

1. Details of Diagnosis…………………………………………………………………………………………….
2. Date of First Consultation………………………………………………………………………………….
3. Date of Diagnosis……………………………………………………………………………………………..
4. History of Present Illness………………………………………………………………………………….
5. Any other past Medical History……………………………………………………………………………
6. Is the Patient likely to expire within 6 months? If yes, please provide a brief summary of medical condition…
   …………………………………………………………………………………..…………………………………………
   ………..
7. What is the prognosis…………………………………………………………………………………………

III. Other Information

1. Name and address of hospital where Patient was admitted: ……………………………………………………..
………
2. Date of Admission…………………………….. 3. Date of Discharge ……………………………….
3. Any other information, which in your opinion will assist us in a assessing this claim? If "Yes", please give details below.

………

I.………………………………………………………………………………………………….Medical Attendant of the Life Assured ……………………………………………………….do hereby solemnly declare that foregoing statements are true and correct to the best of my knowledge and belief.

Dated at……………………….this………………..day of…………………………..20…

Stamp of Medical Attendant

Signature of Medical Attendant………………………..
Name of Medical Attendant ………………
Qualifications……………………………………………
Phone number …………………………………………..
Mobile No……………Email ID…………………………

Ver 1.1 June 05, 2012