

**Attending Physicians Statement For Dread Disease/ Critical Illness Benefit Claim- Form-DD**

(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)

<b>I. General Information</b>	
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.....	
<b>II. Information about the Dread Disease/Critical Illness</b>	
1. Exact Diagnosis.....	
2. Date of First Consultation.....	
3. Date of Diagnosis.....	
4. Date of Surgery.....	
5. History of Present Illness.....	
6. Any other past Medical History.....	
7. What is the prognosis.....	
<b>III. Other Information</b>	
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 the above statements are true and correct to the best of my knowledge and belief.	
Dated at.....this.....day of.....20...	
<div style="border: 1px solid black; height: 60px; width: 100%; margin-top: 20px;"></div> <p align="center">Stamp of Medical Attendant</p>	Signature of Medical Attendant..... Name of Medical Attendant .....
	Qualifications..... Phone number .....
	Mobile No.....Email ID.....