Attending Physician's Accelerated Terminal Illness Premier Rider

(Questionnaire to be completed by the specialist/Hospital which treated the life insured for his illness)

Name of Life insured:_____ Age: ☐☐ Years: Y Y Y Y

Occupation:_____ Any identification Marks:_____

Address:_____

Admission:

Date: D D M M Y Y Y Y Time:_____

Life insured History:_____

_____

Discharge date: D D M M Y Y Y Y

Examination and Diagnosis:

1. Kindly describe in brief the symptoms of the illness noticed on examination?

_____

_____

2. How long do you believe the symptoms had been present when you were first consulted?

_____

_____

3. Were the symptoms noticed on examination consistent with the history reported on consultation/admission? If not, please state what in your opinion could have caused the illness.

_____

_____

4. Is there anything in the family history which would have increased the risk of his condition?

_____

_____

5. What was the final diagnosis and when was the life insured informed about it?

_____

_____

6. How accordingly to you is the prognosis of the life insured on account of the diagnosis of the current disease?

_____

_____

7. Due to the ailment suffered by the life insured, what is the probable period of life expectancy anticipated for the life insured?

_____

_____

To be filled only in case of surgeries performed on the life insured

Date of surgery: _____

Nature of surgery: _____

Performed by: _____

Hospital Name: _____

Hospital Address: _____

_____

Hospital Contact no: | | | | | | | | | | |

Treatment:

1. Kindly give particulars of treatment given?

_____

_____

2. What is the present condition of the life insured?

_____

If there is any further information, which in your opinion will assist us in assessing this claim, please furnish the information below:

_____

_____

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.

Name of the Doctor/Hospital: _____

Registration No. | | | | | | | | | | | | |

Contact no: | | | | | | | | | | |

Address: _____

_____

_____

Signature & Seal

Date: D D M M Y Y Y Y

Place: _____

Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned address:

FOR/1/17-18/1522