LIFE INSURANCE

Aditya Birla Sun Life Insurance Company Limited

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Doctor's Questionnaire

(To be completed by the doctor/Hospital that treated the Life Insured for his/her injury as a result of accident – for dismemberment rider claim)

Policy Number: ☐☐☐☐☐☐☐☐☐☐☐☐ Name of Life Insured _____

Address of the Life Insured _____

Date of Birth: ☐☐☐☐☐☐☐☐ Age: ☐☐

Occupation (including description of duties): _____

Last day at work _____ Occupation: _____ Qualification: _____

Any identification Marks: _____

Admission Date: ☐☐☐☐☐☐☐☐ Time: _____ Place: _____

Name of the Hospital: _____

Patient History: _____

_____

Discharge Date: ☐☐☐☐☐☐☐☐

Examination and Diagnosis:

1. Are you currently under treatment for this condition?

_____

_____

2. Kindly describe in brief the nature of injuries noticed on examination?

_____

_____

3. Was the nature of injuries noticed on examination consistent with the history reported on consultation/admission? If not, please state what in your opinion could have caused the injuries.

_____

_____

4. What was the final diagnosis and when was the patient informed of the same?

_____

_____

5. Kindly state the nature of deformity, injury in brief, which contributed to the causes leading to dismemberment?

_____

_____

Treatment:

1. Kindly give particulars of treatment given?

2. What is the present condition of the patient?

3. In your opinion is the patient unable to follow his usual vocation and if so, please state why?

4. Kindly state the percentage of dismemberment?

5. Which parts of the body are affected due to injury?

6. In your opinion, what would be the time required for the patient to recover fully from the dismemberment?

7. Have you any information or remarks to make concerning the ailments, habits or way of living of the patient which may have a bearing on the dismemberment?

Name of Doctor: _____ Registration Number: | | | | | | | | | | |

Postal Address: _____

Landline No.: | | | | | | | | | | | Mobile No.: | | | | | | | | | | |

Email address: _____ Qualification: _____

Declaration:

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospital and that any information that could influence a decision regarding this claim has not been withheld. 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.

Full Signature of Doctor:

Date of report: D D M M Y Y Y Y

FOR/1/17-18/1521