Birla Sun Life Insurance

MEDICAL CERTIFICATE FOR DISABILITY

Name of the Life Insured:_____ **Policy Number** _____

Patient / Claimant Details

To: Dr _____

Address : _____ Name: _____

_____ Policy No.: _____

_____ Date of Birth. _____

Doctors Details

Name of Doctor: _____ Registration Number: _____

Postal Address: _____

Telephone No.: _____ Fax No.: _____

Email address: _____ Qualifications: _____

I declare that to the best of my belief and knowledge, the information contained in this report is true, accurate and complete and that any information that could influence a decision regarding this claim, has not been withheld.

Signature of Doctor: _____ Date of Report _____

CLAIMANT'S DETAILS

Full Name of Claimant: _____

Date of Birth: _____ Policy No.: _____

Telephone Number: _____ Facsimile No.: _____

Occupation (including description of duties: _____

_____

Qualification : _____ **Last day at work:** _____

MEDICAL HISTORY

1. Diagnosis and reason for claim: _____

_____

2. Date symptoms started: _____

3. Date first seen by you for this reason: _____

4. Date stopped work: _____

5. Date seen by you for any other conditions (please give dates and details below).

Date	**Reason for Consultation**	**Treatment Prescribed**	**Duration of Complaint**

MEDICAL REFERENCES

Please give the details of any other Practitioners, Specialists or Hospitals to who the claimant has been referred. Please include copies of all available Specialist reports

Name of Practitioner / Hospital	
Speciality	
Postal Address	
Complaints referred for	

Name of the Life Insured:_____ **Policy Number** _____

Medical History

Please give full medical history, including the following.

- Symptoms and diagnoses
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. lung function readings, X-ray or scan results)
- Treatment and response
- Other comments

_____

_____

_____

_____

_____

_____

Current major complaint(s) _____

_____

RESULTS OF MOST RECENT MEDICAL EXAMINATION

Date of Examination _____

Please give full clinical details as at the examination, including height, weight, and blood pressure readings. Please include details of any limitations evident at the examination (e.g. joint limitations, visual acuities).

_____

_____

_____

_____

PROGNOSIS

What are chances of recovery Good/Fair/Poor/Nil)? _____

Are any residual problems likely? Please specify: _____

_____

_____

Date expected to return to work: _____

DOES THE CLAIMANT USE TOBACCO IN ANY FORM? YES ☐ No ☐

If "yes" please provide details: _____

IS CURRENT MEDICAL IMPAIRMENT DUE TO:

a)	Previous illness or injury	Yes ☐	No ☐
b)	The intentional consumption of alcohol, narcotics or any toxic substance	Yes ☐	No ☐
c)	Attempted suicide or any self inflicted injury	Yes ☐	No ☐

Name of the Life Insured:_____ **Policy Number** _____

Please comment on the member's ability to carry out the specified activities in the table below.

ACTIVITY	CURRENT LIMITATIONS				EXPECTED FUTURE ABILITY		
	No Limitation	Partial Limitation	Impossible	Danger to self and others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly and making decisions							
Interacting with others							
Walking (non-strenuous) over level ground							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Use of both arms and legs							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							

General comments, which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated.

_____

_____

If period off work longer than usually expected for impairment, please give reason.

_____

TREATMENT AND REHABILITATION

Current treatment regime. Please specify all medications and dosages:

_____

_____

_____

Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy):

_____

_____

_____

_____

Name of the Life Insured:_____ **Policy Number** _____

Planned future treatment, including surgery:

_____

_____

_____

_____

_____

Your recommendations regarding rehabilitation (if applicable)

_____

_____

_____

_____

Medical Attendant

Name : _____ Signature:_____

Address : _____

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.

PLEASE ATTACH COPIES OF ANY CORRESPONDENCE RECEIVED FROM ANY PRACTITIONERS, SPECIALISTS OR HOSPITALS IN RESPECT OF THE CLAIMANT.

Birla Sun Life Insurance Company Limited
G-Corp Tech Park, 5th & 6th Floor, Kasar Wadavali, Ghodbunder Road, Thane (W)- 400 601.
Tel.: 39961000 Email Id: claims@birlasunlife.com
Regd. Office: One Indiabulla Centre, Tower 1, 15th & 16th Floor, Jupiter Mill Compund, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai – 400 013. Tel. No.: 43569000