GENERALI Central
LIFE INSURANCE

MEDICAL QUESTIONNAIRE FOR DEATH CLAIM

(To be filled by the physician who last attended the Insured)

Policy No.		Claim no.	

INFORMATION ABOUT THE DECEASED			
1. Full Name			
2. Father/Husband's Name			
3. Address			
4. Age (years)		Gender	☐ Male ☐ Female

DEATH & ILLNESS DETAILS			
1. Date on which you were **First consulted for current illness:**			
2. Date on which you have **Last attended for current illness:**			
3. What was the mode of approach: ☐ Himself ☐ Family Relatives ☐ Friends ☐ Neighbours			
4. Date of Death	☐	5. Time of Death	☐ am ☐ pm
6. Primary cause of death			
7. Antecedent cause of death		8. Place of Death	
9. First date of diagnosis			

10. How long, in your opinion did deceased had been suffering from this disease/condition?

11. While examining the Life Assured, have you seen any past medical records?
If Yes, please share details (Attach copies- if available)

12. Who certified the cause of death? If certified by yourself, please attach a copy of the Medical Cause of Death Certificate

13. Physician's Signature & seal/stamp:

14. Was the Post Mortem conducted? If Yes, please provide details of the hospital

15. Any other significant condition/cause contributing to the death: (e.g. Alcohol consumption, Smoking, Drug abuse etc. along with quantity & duration of its consumption)

16. Have you treated or given any advise on illness to the deceased during past 5 years prior to last illness? If yes, please provide details?

17. Did the deceased, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:

Name of Hospital/Doctor	Date of Consultation	Symptoms/Complaints	Diagnosis/ Tests undergone

18. Any additional information (pertaining to deceased past medical history/Life style) which could help us to process the claim?

I hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Physician's Name: Dr. _____ Signature & seal/stamp _____

Name & Address of Hospital/Clinic _____

_____

Registration No. _____ Tel. /Mobile no.: _____

Date _____ Place _____