**Bharti AXA Life Insurance Company Limited**
**Unit No. 601 & 602, 6th floor, Raheja Titanium, Off Western Express Highway,**
**Goregaon (East), Mumbai - 400 063.** www.bharti-axalife.com Call Centre: 020 26141350
Toll Free: 1800-102-4444 (for Airtel subscribers); 1800 425 1350 (for MTNL/BSNL subscribers)

# TREATING DOCTOR'S CERTIFICATE

(To be completed by the doctor who treated / attended the Life Insured)

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers Please give the following information correctly and completely to enable us process your claim promptly.

| Name of Life Insured ('Patient') | Age at Event |
|---|---|
| | |

1. Name of the Hospital: ……………………………………………………………………………………………………..
2. Address and contact no. of the Hospital: ……………………………………………………………………………….

……………………………………………………………………………..…………………………………………..……

……………………………………………………………………………..…………………………………………..……

3. Date of admission into the Hospital: ……………………………… Time of Admission: ………………………………….
4. Date of Discharge from Hospital: ………………………………….Time of Discharge: ………………………………….
5. Symptoms complained of: …………………………………………………………………………..………………
6. Duration of the illness: ……………………………………………………………………………..……………………..
7. History reported by: ……………………………………………………………………………...……………………...
8. Diagnosis arrived: ……………………………………………………………………………..………………………..
9. Treatment given**:** ……………………………………………………………………………………….……………………

   ……………………………………………………………………………………………………………………………….

10. Please provide the Risk Factors of the Patient
11.

| Sr. No. | Risk Factor | Status | Status | Duration |
|---|---|---|---|---|
| 1 | Diabetes | Y | N | |
| 2 | Hypertension | Y | N | |
| 3 | Angina / IHD | Y | N | |
| 4 | Thyroid Disorder (hypo / hyper) | Y | N | |
| 5 | Smoker (pl. specify qty / day) | Y | N | |
| 6 | Alcohol (pl. specify qty / day) | Y | N | |
| 7 | Occupational Hazard | Y | N | |
| 8 | Any other | Y | N | |

12. Has the patient any history of previous hospitalizations / surgeries. (If 'YES' kindly provide us the details)

| Sr. No. | Reason / Surgery | Dates |
|---|---|---|
| 1 | | |
| 2 | | |

Drugs History (If 'YES' please mention generic name)

| Sr. No. | Drugs Name & Dose | Duration |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

13. Has the patient previously suffered from any similar illness? If 'Yes', please provide details.

(i) Name of disease: ……………………………………………………………………………………………………..

(ii) Date/Month/Year of Diagnosis …………………………………………………………………………………….

14. Is the Patient suffering from any other major, chronic or congenital disease? If yes, please provide details.

(i) Name of disease: ……………………………………………………………………………………………………..

(ii) Date/Month/Year of Diagnosis …………………………………………………………………………………….

15. Has the patient referred to any other Doctor for current / associated ailment? If so, please furnish details below:

(a) Name and address of the doctor / hospital: …………………………………………………………………….

………………………………………………………………………………………………………………………

Date of referral:………………………………History reported: ……………………………………………...............

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Signature & Seal: …………………………………………………………………………………………………….

| Name of Doctor | | Registration No. | |
|---|---|---|---|
| Qualification | | Specialization ( if any ) | |
| Address | | | |
| Contact Numbers | | Date | |