Max New York Life Insurance Company Ltd.
12th Floor, DLF Square Building, Jacaranda Marg, DLF Phase II, Gurgaon 122 002
Phone 2561717 (From Delhi +95124, other cities +0124)

FORM C

ATTENDING PHYSICIANS STATEMENT FOR DEATH CLAIM

(A qualified and registered medical practitioner should complete this form. Spouse, or Lineal Relative of the Policy Holder/Life Insured who are medical practitioners cannot complete it)

I. General Information

1 a) Name of the Life Assured…….. b) Age……

2. Were you the Life Assured's usual doctor? If "yes", please give details. How long have you known the deceased?
……..

3. Date of Death…….. 4.Immediate Cause of Death……

5. Underlying Cause of Death…….. 6. Duration of Ailment…….

7. Was the deceased referred to you by another Doctor or Hospital? If "Yes", please give details:

Name of Doctor/ Hospital…….Address of Doctor/Hospital……

II. Information about the Illness/Accident

1. Details of Illness/Accident…….
.
2. Date of First Consultation ……..

3. Date of Diagnosis…….

4. What were the Life Assured's presenting complaints……..

5. History of Present Illness…….

6. Any other past Medical History……

7. Did the deceased suffer from any other ailment other than the ailment that eventually led to death?
☐ Yes ☐ No
If yes, give brief particular of it with duration and treatment rendered.
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III. Other Information

1. Name and address of Hospital where Life Assured was admitted: ……
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2. Date of Admission…….. 3. Date of Discharge/Death ……

4. Admission No./C.R. No./I.P. No ……

5. Please give details of treatment rendered for the current Ailment. (Or any treatment taken in the past for the same)

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I……Medical Attendant of the Life Assured ……do hereby solemnly declare that foregoing statements are true and correct to the best of my knowledge and belief.

Date:

Signature of Medical Attendant……..
Name and Stamp of Medical Attendant ……..
Qualifications……
Phone number ……
Mobile No……..Email ID…….