Policy No.:
Claim No.:

Tata AIA Life Insurance Company Limited

(hereinafter called "Tata AIA" or "the Company", whichever is applicable)

CERTIFICATE OF MEDICAL ATTENDANT

To be completed in BLOCK letters by a duly qualified and registered medical practitioner at the claimant's expense. Please answer all questions, use "not applicable" (N/A) as appropriate instead of leaving it blank. Counter-sign where amendments/alterations are made in the form.

Patient Name	Age Sex
Patient's Occupation	I. D. No.
Patient's Address	I. D. Document Type

Consultation Details

If due to ILLNESS, please provide:	**If due to ACCIDENT**, please provide:
Chief complaints & presenting symptoms	Conditions of injury & parts of body involved
	Is there external visible evidence of injury at your first consultation: If yes, give details
Date symptoms first appeared	Date of injury
Your Diagnosis	Cause of injury

Date of your consultation of this illness/injury

First consultation on Last consultation on

Past medical history, family history and co-morbid conditions (please give consultation dates & details)

Hospitalization Details

Does this illness/injury necessitate inpatient hospitalization: ☐ No ☐ Yes, details as below:-

Hospital Name	Date & Time of Admission
Address	Date & Time of Discharge

Any surgical procedure performed? ☐ No ☐ Yes, details as below:-

Date of operation	Place of operations
Name of surgical procedure	Surgeon Name & Registration No.

Tests & investigations performed? ☐ No ☐ Yes, details as below:-

Name of test/investigations Date(s) Results (please enclose a certified true copy of the test results)

Other treatments administered (medicines, dressing & suturing etc)

Discharge summary & treatment plan

Registered and Corporate Office : Tata AIA Life Insurance Company Ltd. (IRDA Regn. No. 110),14th Floor, Tower A, Peninsula Business Park, Senapati Bapat Marg, Lower Parel, Mumbai 400013. CIN: U66010MH2000PLC128403.

Dates of follow-up consultations with you after hospital discharge **for the same illness/injury** Date(s) Condition	
Was healing complicated? If yes, state reasons and any special treatment given.	☐ No ☐ Yes, details as below:-
Bearing in mind the patient's occupation, do you feel the illness/injury would have prevented him/her from working at your first consultation at your last consultation	 ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____
If absence from work more than 2 weeks was necessary, please state the reasons.	
Is the illness/injury related to (a) Physical defects/congenital anomaly (b) Unfavourable past medical history (c) Degenerative changes (d) Alcohol, drug, or nicotine/smoking (e) AIDS or HIV infection (f) Suicide or self-inflicted injury	 ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____ ☐ No ☐ Yes, details: _____

Other doctors/hospitals involved in the care of the patient

Name	Address	Telephone No.

Declaration by the Attending Physician/Specialist

I declare that the answers given are true and complete.

I declare I am duly licensed and registered to practice western medicine (allopathy) in India (if outside India, please state where _____)

Certification by Hospital Admitted, that

1) The Hospital is duly licensed and registered as a Hospital to provide treatment in western medicine (allopathy) in India (if outside India, state where _____) for the care and treatment of sick and injured persons as registered in-patients, fully equipped with facilities for diagnosis and major surgery which are under the constant supervision of one or more Registered Medical Practitioners, and which have 24-hour a day full time professional nursing services; And

2) Maintains proper medical and patient records and quality health care to the standards as required under the prevailing laws and regulations in the geographical area it is located; And

3) Is not an institution operated as a convalescent or rest home, a hotel, a home for the aged, a place for alcoholics or drug addicts, or Custodial Care, or for any similar purpose.

4) The Hospital has on the following facility and resource (please state)
No. of in-patient beds : _____
No. of qualified registered resident doctors: _____
No. of qualified registered full time nurses : _____

_____ Signature of Attending Physician/Specialist (with qualifications)	_____ Signature of authorized Hospital Administrator
[Name in Block:]	[Name in Block:]
_____ Registration No. & Place	_____ Name of Hospital
_____ Address & Official Stamp	_____ Registration No. & Place
_____ Telephone	_____ Address & Official Stamp
_____ Mobile No.	_____ _____ Telephone Fax No.
_____ Email Address	_____ Email Address
_____ Date	_____ Date

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CLP/P4.9/4.T39 (I)

Version 1

Hospital Information Sheet

Please provide your answers in the right column and return it to us at the following address for our database:
Tata AIA Life Insurance Co. Ltd.
2nd Floor, Delphi-B Wing, Arcade Avenue,
Hiranandani Business Park, Powai, Mumbai - 400 076.
Attn: Claims Department

▪ Name of hospital : ▪ Registration no. & Registering authority & Place : ▪ Address : ▪ Tel. No. : ▪ Fax no. : ▪ Web site :	
▪ Name of contact person : ▪ Designation : ▪ Telephone no. : ▪ Email address : ▪ Name of Owner (if different from contact person above) :	
The Hospital provide treatment in (tick as appropriate) :	☐ western medicines (allopathy) ☐ alternate medicines (state details) _____
Specialties available (e.g. Paediatrics, Orthopaedics, ENT etc) If yes, please state details:	
▪ No. of in-patient beds:	
▪ No. of qualified registered resident doctors : For government hospitals, please also state ▪ No. of Professor doctors: ▪ No. of Assistant Professor doctors: ▪ No. of Lecturer doctors:	
▪ No. of qualified registered full time nurses :	
▪ In House facility available [please state Yes in the right column if available]	
▪ Pathology Lab. :	
▪ Oxygen : - Central supply : - Cylinder :	
▪ E. C. G. :	
▪ X Ray : ▪ Ultrasonography : ▪ C. T. Scan : ▪ M. R. I. Scan :	

▪ Pathology :	
▪ Blood Bank :	
▪ Operation Theatre :	
▪ Labour room / delivery room :	
▪ I. C. C. U.:	
▪ Cardiac monitor :	
▪ Defibrillator :	
▪ Ventilator :	
▪ Emergency Room :	
▪ Day Care Centre :	
▪ Outpatient consultation :	
▪ Computerized access to patient records :	
▪ Other facilities – please state details :	

The above information is certified to be true and complete.

_____ _____

Signature of Hospital Administrator Date

[Name in Block:]

_____

Hospital Name & Official Stamp