IDBI FEDERAL
In association with Ageas
IDBI Federal Life Insurance Co Ltd
IRDA Regn. No. 135. | Corporate Identity Number: U66010MH2007PLC167164.
22nd Floor, A Wing, Marathon Futurex, N.M. Joshi Marg, Lower Parel (East), Mumbai - 400013, Maharashtra, India
Toll Free: 1800 209 0502 (Monday to Saturday; 8 am to 8 pm). E-mail: support@idbifederal.com.
www.idbifederal.com

Physician's Statement

General instructions:

1. This statement needs to be filled up by the Medical Practitioner on his / her letterhead.
2. **If you are in possession of any medical records or data regarding the life insured's health condition, then please submit the requisite documents along with this statement.**

Our Ref: IDBI Federal/Claim No- /Mumbai/Policy No.

Name of the life insured:

Residential address of the life insured:

A. Are you the family physician for the life insured? Yes/No
If yes, then since when?
If not, please provide the name and contact details of the family physician?

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B. If the life insured was hospitalized due to natural causes(illness/sickness):

1. Date and time of admission .....
   Date and time of discharge .....
   Exact Duration (in hrs) if admitted in ICU.....

2. Exact Cause (s) of hospitalization(diagnosis)
   .....
   .....

3. Date of first consultation.....
   Nature of Aliment: .....
   Duration of Aliment:.....
   Patient Reference No:.....

4. Date of last consultation.....
   Nature of Ailment: .....
   Duration of Ailment:.....
   Patient Reference No:.....

5. A. Other significant health conditions/ secondary cause (s) contributing to hospitalization
   ……
   ……
   B. Duration (i.e-in months /years)
   i……
   ii……
   iii……

6. Was the life insured informed about the findings and / or diagnosis made by you during the consultations? Was he also appraised about the extent and severity of the condition diagnosed?
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   ……
   ……

7. Has the life insured sought any treatment, medical or interventional, or any health advice from you during the past five years prior to the last illness? ……
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8. In your knowledge, has the life insured ought or received any treatment, medical or interventional, or any health advice from any other physician or hospital etc. during the past five years prior to the last illness? ……
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   If yes, then please provide the following information:
   Name of physician (s) or hospital (s) ……
   ……
   Address of physician (s) or hospital (s) ……
   ……
   Dates of examination (s) ……
   Diagnosis: ……

9. Whether his / her habits were regular and moderate? Yes/No

10. Are you the family physician for the life insured? Yes/No
    If yes, then since when?
    If not, please provide the name and contact details of the family physician?

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C. If the life insured was hospitalized due to unnatural causes (i.e.-accident):

1. Date and time of admission ……
   Date and time of discharge ……
   Exact Duration (in hrs) if admitted in ICU……
   Patient Reference No:……

2. Exact Cause (s) of hospitalization (diagnosis)
   ……

3. Was the Police informed and FIR registered? ……
4. Driving License no of the life insured? ……
5. If yes, then by whom was it carried out and what were the findings, if this is in your knowledge?
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Declaration by the physician:

The above-mentioned facts are true in their entirety and to the best of my knowledge and belief.

"The information is based on records maintained in the Register No …… Entry No…… Dated……."

Name of the physician……

Qualifications ……
Postal Address
…… ……

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Contact No (with STD Code)……

Signature and Stamp of Physician……

Registration

No……

Dated:……