



Form 'D'

MAX NEW YORK LIFE INSURANCE CO. LTD.

HOSPITAL TREATMENT CERTIFICATE

Home Office: - Gurgaon

General Office.....

This is relating to death claim under policy no.....on the life of (Full Name of the Deceased).....

1. Following information should be as per Hospital records:

Name.....
 Age..... Occupation.....
 Address.....

 Any Mark(s) of identification.....

2.	Date & Time of Admission & Admission No.	..... .....
3.	If the patient was referred to you, name & Add. Of Hospital/Doctor concerned.	..... ..... .....
4.	Nature and Duration of illness at the time of Admission.	..... .....
5.	a) Exact history of illness reported at the time of admission.	..... .....
	b) Was this reported by the patient, if not, by whom it was so reported?	..... ..... .....
	c) Please give the details of doctor recording the above history.	..... ..... .....
6.	Did the deceased suffer from any medical ailment in the past. Please provide details of the same.	..... ..... .....
7.	What was the diagnosis arrived at in the Hospital?

Max New York Life Insurance Company Ltd.

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Phone 2561717 (From Delhi +95124, other cities +0124)

8.	Please provide details and dates of the investigations conducted during the stay in the hospital to confirm the diagnosis. Attach separate sheets if required.
9	Was point number 8 reported by the patient, if not, by whom it was so reported?	
10.	When was the diagnosis confirmed	..........
11.	Was there any other disease/illness prior to or co-existed with the ailment at the time of admission in to hospital. Give brief particulars of it.	..... ..... .....
12.	Date of his/her discharge from Hospital.	.....
13.	Condition at the time of discharge.	..... .....
14.	Please give details of the treatment rendered to the deceased	....................
15.	Was he/she treated in the hospital on any previous occasion as an outpatient. If yes, please state details.	

Certified that the above information is correct as per records of the Hospital.

Date.....
 Signature
 Name of the Doctor
 Code No.....
 Qualification and designation.....
 Name of the Hospital.....
 Postal Address of the Hospital.....

 Telephone Number (with STD code).....
Hospital Seal/ Stamp