



**FUTURE
GENERALI**

TOTAL INSURANCE SOLUTIONS

MEDICAL QUESTIONNAIRE FOR DEATH CLAIM

(To be filled by the physician who last attended the Insured)

Policy No.		Claim no.																	
INFORMATION ABOUT THE DECEASED																			
1. Full Name																			
2. Father/Husband's Name																			
3. Address																			
4. Age (years)		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female																
DEATH & ILLNESS DETAILS																			
1. Date on which you were First consulted for current illness:																			
2. Date on which you have Last attended for current illness:																			
3. What was the mode of approach: <input type="checkbox"/> Himself <input type="checkbox"/> Family Relatives <input type="checkbox"/> Friends <input type="checkbox"/> Neighbours																			
4. Date of Death	<u> </u> / <u> </u> / <u> </u>	5. Time of Death	<input type="checkbox"/> am <input type="checkbox"/> pm																
6. Primary cause of death																			
7. Antecedent cause of death	8. Place of Death																		
9. First date of diagnosis																			
10. How long, in your opinion did deceased had been suffering from this disease/condition?																			
11. While examining the Life Assured, have you seen any past medical records? If Yes, please share details (Attach copies- if available)																			
12. Who certified the cause of death? If certified by yourself, please attach a copy of the Medical Cause of Death Certificate																			
13. Physician's Signature & seal/stamp:																			
14. Was the Post Mortem conducted? If Yes, please provide details of the hospital																			
15. Any other significant condition/cause contributing to the death: (e.g. Alcohol consumption, Smoking, Drug abuse etc. along with quantity & duration of its consumption)																			
16. Have you treated or given any advise on illness to the deceased during past 5 years prior to last illness? If yes, please provide details?																			
17. Did the deceased, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:																			
<table border="1"> <thead> <tr> <th>Name of Hospital/Doctor</th> <th>Date of Consultation</th> <th>Symptoms/Complaints</th> <th>Diagnosis/ Tests undergone</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>				Name of Hospital/Doctor	Date of Consultation	Symptoms/Complaints	Diagnosis/ Tests undergone												
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18. Any additional information (pertaining to deceased past medical history/Life style) which could help us to process the claim?																			

I hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Physician's Name: | Dr. _____ | Signature & seal/stamp | _____ |

Name & Address of Hospital/Clinic | _____ |

| _____ |

Registration No. | _____ |

Tel. /Mobile no.: | _____ |

Date | _____ |

Place | _____ |