Bharti AXA Life Insurance Company Limited
Unit No. 601 & 602, 6th floor, Raheja Titanium, Off Western Express Highway,
Goregaon (East), Mumbai - 400 063. www.bharti-axalife.com
Toll Free: 1800-102-4444

FAMILY PHYSICIAN'S CERTIFICATE

(To be completed by the doctor who treated / attended the Life Insured)

No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Name of Life Insured ('Patient')	Age at Event

1. Please provide details of the first consultation by the Patient. *Please enclose copies of all relevant medical reports.*

(a) Date of consultation:.....

(b) Symptoms:.....

(c) Duration of the symptoms: .....History reported by: .....

(d) Diagnosis arrived at: .....

(e) Treatment given: .....

2. Please provide the Risk Factors (Personal) of the Patient

Sr. No.	Risk Factor	Status	Status	Duration
1	Diabetes	Y	N	
2	Hypertension	Y	N	
3	Angina / IHD	Y	N	
4	Thyroid Disorder (hypo / hyper)	Y	N	
5	Smoker (pl. specify qty / day)	Y	N	
6	Alcohol (pl. specify qty / day)	Y	N	
7	Occupational Hazard	Y	N	
8	Any other	Y	N	

3. Has the patient any history of previous hospitalizations / surgeries. (If 'YES' kindly provide us the details)

Sr. No.	Reason / Surgery	Dates
1		
2		
3		
4		
5		

Drugs History (If 'YES' please mention generic name)

Sr. No.	Drugs Name & Dose	Duration
1		
2		
3		
4		
5		

4. Has the patient previously suffered from any similar illness? If 'Yes', please provide details.

(i) Name of disease :.....(ii) Date of diagnosis:.....

5. Was there any other antecedent or contributory disease / disorder or ailment? If 'Yes', please provide nature and duration of the disease / disorder or ailment.

……

6. Is the Patient suffering from any other major, chronic or congenital disease? If yes, please provide details.

(i) Name of disease :……(ii) Date of diagnosis:……..

7. Was the history provided by the Life Insured ('Patient') / others? If 'others' please furnish details below:

(a) Name and relation with the Life Insured:……..

8. Has the patient referred to any other Doctor for current / associated ailment? If so, please furnish details below:

(a) Name and address of the doctor / hospital:……

……

Date of referral:……History reported: ……

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Signature & Seal:……

Name of Doctor		Registration No.	
Qualification		Specialization (if any)	
Address			
Contact Numbers		Date	