# Family Physician's Statement Critical Illness Rider

To be filled by Family Physician

Name of Patient: _____

Policy Number: | | | | | | | | | | | | | | | Date of Birth: | D | D | M | M | Y | Y | Y | Y | Age: | | |

Address: _____

_____

Contact No./ Mobile No.: | | | | | | | | | | |  Occupation: _____

Identification Marks: _____

1. Date on which you first attended the patient for the illness. | D | D | M | M | Y | Y | Y | Y |
2. How long do you believe the symptoms had been present when you were first consulted?

   _____

   Please describe the underlying cause of the patient's condition.

   _____
3. Give full and exact details of the diagnosis and when was the patient informed of the same.

   _____
4. Are you the patient's regular attending physician? If yes, since how long?

   _____
5. What is the patient's past health history and is there anything in the patient's family history that would have increased the risk of his condition?

   _____
6. Please provide details of physician(s) to whom the patient has been referred for the illness.

| Name, addresses and Contact no. of physician(s) &/or hospital(s) | Date of consultation and period of confinement(s) | Reason for taking the treatment |
|---|---|---|
| | | |
| | | |

7. Kindly provide copies of prescription/ indoor case papers with the findings of the investigations done

| Types of Tests conducted | Date of Test conducted | Laboratory where the tests were conducted | Findings |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

FOR/11/17-18/1120

**Customer Acknowledgement Slip**

Policy No.: | | | | | | | | | | |  Reference No.: _____

Type of requirement:

Received by: _____  Date: | D | D | M | M | Y | Y | Y | Y |

Employee Code: _____  Signature: _____

If there is any further information, which in your opinion will assist us in assessing this claim, please furnish the information below.

Name of the physician: _____

Registration no.: _____ Email Id: _____

Address: _____

Tel No.: | | | | | | | | | | Mobile No.: | | | | | | | | | | |

## Declaration

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy. Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned address:

Date: | D | D | M | M | Y | Y | Y | Y | Place: _____

_____

Signature with Stamp