

Attending Physician's Statement

(To be filled up by the Attending Doctor/Physician)

Please provide the following details of the Patient/Insured Person

Name Mr. Mrs.

Age Sex M F

Address

Flat Building Road/Street/Sector

Area

Taluka/Village/District/City Pin Code State

Country Fax

Email Id: Phone No.

Please specify the date & time when the Patient/Insured Person first contacted you _____

Please provide the details of the diagnosis and treatment given for the disease/illness/ injury _____

Please provide the details of medical investigation done, if any _____

In case of accidental injury

Does the cause of accident as stated by the Patient/Insured Person tally with the injuries noticed by you? _____

Was the Patient/Insured Person suffering from any condition/disease/illness/injury which may have contributed to the accident or likely to aggravate his/her condition: Yes No

If yes, please specify the necessary details _____

Was the Patient/Insured Person under the influence of alcohol or intoxicants or drugs at the time of accident? Yes No

If yes, please specify the necessary details _____

In case of disease/illness

When did the Patient/ Insured Person's symptoms first appear? _____

Please specify the cause of the disease/illness _____

Was the disease/illness caused and/or aggravated due to any pre-existing condition/ disease/illness/injury ? Yes No

If yes, please give the necessary details: _____

Is the condition due to pregnancy? Yes No

Was the Patient/Insured Person hospitalized for the treatment of the disease/illness/injury? _____

If yes, please provide the following details

Period of Hospitalization: From to

Name of Hospital/ Nursing Home where treatment of the disease/illness/injury was given:

Address

Flat Building Road/Street/Sector

Area

Taluka/Village/District/City Pin Code State

Country Fax

Name of the attending Doctor/Physician Dr. _____

Address

Flat Building _____ Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____ State _____

Country _____ Fax _____

Email Id _____ Telephone _____

Mobile No _____

Date: _____

Attending Doctor's/Physician's Signature

Place: _____

Compassionate Visit

Please specify the details of disease/illness/injury: _____

Date of accident/onset of ailment: _____

Was the Patient/Insured Person hospitalized? Yes No

Period of Hospitalization: From _____ To _____

Please provide the details of the treatment given: _____

Please provide the following details of the Hospital/Nursing Home where the treatment for disease/illness/injury was taken:

Name of the Hospital /Nursing Home _____

Address

Flat Building _____ Road/Street/Sector _____

Area _____

Taluka/Village/District/City _____ Pin Code _____ State _____

Country _____ Fax _____

Email Id: _____ Telephone _____

Mobile No. _____

Was the disease/illness/injury caused due to or aggravated by any pre-existing condition/disease/ illness/injury: Yes No

If yes, please specify the necessary details _____

In the opinion of the treating doctor , how many days of hospitalization would the Patient/Insured Person require? _____

In the opinion of the treating doctor, is there a need for an attendant for the Patient/Insured Person : _____

Please fill in the following details, only in case the Patient/Insured Person has opted for the Reliance Travel Care Insurance Policy- Student Plan

Please specify as to who has been hospitalized: Patient/Insured Person Immediate family member of the Insured Person

Name of the family member hospitalized: _____

Relationship with the Patient/Insured Person: _____