Pramerica | LIFE INSURANCE

Last Medical Attendant's Report

(This form should be filled by a qualified and registered Medical Practitioner who is other than Policyholder, Life Insured or the Relative

Policy No.

Date: D D M M Y Y Y Y

Personal Details of the Life Insured

Name: _____

Address: _____

_____

Apparent Age at the Time of Death: _____

Details Relating to Death

Date of Admission: _____

Date & Time of Death: _____

Place of Death (Address): _____

_____

Was Post-Mortem Performed on the Life Assured? Yes/No	If yes, Name and Address of the Hospital where the Post Mortem was performed:

Primary Cause of Death: _____

_____

Secondary Cause of Death: _____

_____

Symptoms prior to Death: _____

_____

Symptoms Duration prior to Death: _____

_____

Were these causes ascertained by examination after death or from the symptoms and appearances during Life?

_____

_____

Details of History Reported at the Time of Death

Name, Address & Telephone No. of Referring Doctor: _____

_____

Doctor MCI Registration number: _____

Date of First Consultation: _____

Date of First Admission in Hospital: _____

History recorded at the time of Consultion/Admission:

Name of Illness/Complaints	Since when? (Date & Time)

History was given By	Life Insured/Others. If Others: Name: _____ Age: ☐☐☐ Sex: ☐ Male ☐ Female Relationship with the Insured: _____
History was Recorded By	Name: _____ Designation: _____