IME Life Insurance Company Limited

Hathway Complex, Lainchour-26, Kathmandu, Nepal
Phone No:4024071,Fax No:4024075

Certificate of Hospital Treatment

In connection with claim under policy No…… on the life of……

(Insert Full Name of Decease)

1.	What was the full name, age, address, and occupation of the patient as per Hospital records? a) Name b) Age c) Address d) Occupation e) Identification Marks	1) …… a. …… b. …… c. …… d. …… e. ……..……..
2.	What was the date of his admission into the Hospital? Please state his indoor admission into the Hospital?	2) ……..…… ……..……
3.	Under whose treatment was the patient before he was admitted into the hospital? If the patient had brought a letter or a note from any Doctor at the time of admission kindly furnish us with a certified copy thereof.	3) …… …… …… ……
4.	What were the nature of his complaints and the duration of the complaint as reported by him, at the time of admission?	4) …… …… ……..
5.	a) What was the exact history reported by the patient at the time of admission? (Full history including the dates, duration of the ailments, the symptoms narrated etc. to be given) b. i. Was the history reported by the patient himself or by someone else? ii. If not, by whom? (Name and relationship of the person who reported it) was the patient himself or by someone else? iii. To whom was the history reported & by whom it was record. iv. Whether the doctor who records the history is still in your service? If not please state his/her full address.	5) a. …… b. I. …… II. …… III. …… IV. ……

Note: Certified copy of the full history may please be furnished

6. What are the diagnosis arrived at in the hospital?	6……
7. Was there any other disease or illness, which preceded or co-existed with the ailment at the time of the patient's admission into the hospital? If so what was it? Please give details stating. a) History Reported b) Date when such was first observed by patient? c) By whom treated. d) Who reported the history?(If not by the patient himself/herself, please indicated if it was in his/her presence and to his/her knowledge) e) Who recorded this history? (If the Doctor is not with the hospital at present, please give his/her present address	7. a. …… b. …… c. …… d. …… e. ……
8. What was his/her discharge from hospital?	8……
9. What was his/her condition when he/she was discharge?	9……
10 Was he/she treated in this hospital or any other hospital on any previous occasion either as an inpatient or an outpatient? a) Date of 1st admission or first time treatment as an outpatient b) Date of discharge and condition on discharge c) Nature of ailment d) History reported at the time of admission	10…… a) …… b) …… c) …… d) ……

Certified that the above information is correct as per records of the hospital.

Authorized Signatory

Date:

Qualification:

Name of Hospital:

Postal Address: