Form 905/A3

भारतीय जीवन बीमा निगम
LIFE INSURANCE CORPORATION OF INDIA

**LIC's CANCER COVER –TREATING DOCTOR CERTIFICATE/HOSPITAL CERTIFICATE**

**(To be filled by Treating doctor /Oncologist treating the Life Assured for the diagnosed ailment)**

The Benefits under this policy are fixed as per Sum Insured opted by policyholder at proposal stage and has no relation to actual expenses incurred by him before , during or after Hospitalization.

| **Policy number:** | **Name of the Policy holder :** |
|---|---|

## 1. Details of diagnosis (has to be filled by attending physician)

| Particulars | Description | Date if applicable |
|---|---|---|
| Provisional diagnosis | | |
| Tests done and results of the same for confirming the diagnosis | | |
| Final diagnosis | | |
| Type of cancer & site / organ involved | | |
| Histological type and stage/grade of tumor (specify as per TNM classification) | | |
| Disease phase | ☐Primary disease ☐ Relapse | |
| Is the condition | ☐Benign ☐ Malignant | |
| (a) Is tumor completely localized to the tissue or organ of origin? | ☐Yes ☐ No | |
| (b) Is there invasion of adjacent tissues? | ☐Yes ☐ No<br>If yes, please state which tissues? | |
| (c) Is there involvement of regional lymph nodes? | ☐Yes ☐ No<br>If yes, please state site(s) and number of nodes involved_____ | |
| (d) Are there distant metastases? | ☐Yes ☐ No<br>If yes, please state which tissues?<br>_____ | |
| Treatment given | ☐Chemotherapy ☐Radiation therapy ☐Surgery<br>☐Hormonal therapy ☐Any others: | |
| Duration of treatment | | |
| Date of discharge | | |
| If discharged, then condition at discharge & advice given for follow up | | |

## 2. Details of Hospitalization / Treatment:

| | |
|---|---|
| Name, address & tel. no of referring doctor | |
| Date of Admission/ consultation | |

3. History reported at the time of admission/consultation: (has to be filled by attending physician)

| | | |
|---|---|---|
| Details of illness/ Symptoms | | |
| Duration of the above | | |
| *Does any of his family members have a history of cancer ( reported by policyholder/relatives/others*) | | |
| *Had he been tested for HIV ? If yes, please mention date of test* | | |
| *Is that medical conditions or medical procedure was caused directly or indirectly by AIDS, AIDS related complex or infection by HIV.* | | |
| Date of First Diagnosis (in case of a known illness/follow up case) | | |
| Name & telephone no. of the Doctor/ Hospital who first diagnosed/treated the patient | | |
| Any surgeries done prior on in course of treatment of the illness | Name of the surgery | Date of surgery |
| | 1. | |
| | 2. | |
| Name of Hospital where surgery was performed | | |
| *Does any family members have a history of cancer* | | |
| History was given by | Life Assured / Family / others. If others:<br>Name: _____<br>Relationship with the Life Assured: _____ | |
| History Recorded by | Name and designation of the person who recorded the history: _____ | |

4. **Was the patient admitted or treated or hospitalized earlier? If yes, please provide the following details**.

| Date | In – Patient / Out - Patient | Reason for seeking treatment | Details of the Treatment given |
|---|---|---|---|
| | | | |

A Clear copy of Photo ID (eg.PAN Card/ Voter Card/Aadhar Card/ Driving license/ Passport ) of the patient needs to be affixed here and is to be attested by the Policyholder and Medical Attendant /authorized person .

**Signature & name of the medical Attendant/authorized person:**

Address & Tel No:
_____
_____
Stamp & registration no.:

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**I authorize the medical attendant, hospital, physician who has/have treated or examined me for any ailment or illness to divulge any information regarding my health known to them either in the past or present to LIFE INSURANCE CORPORATION OF INDIA and its officers.**

Signature of the Life Assured
Place: Date: