

FORM 24 B
MATERNITY BENEFIT DEATH CERTIFICATE
[Regulation 89A]

Book No.....

Serial No.....

Stamp of the dispensary

Name of the deceased insured woman wife / daughter of

Insurance No.....

I certify that in my opinion the above named deceased insured woman died on200...
as a result of..... During her confinement* / during a period of
Weeks immediately following her confinement,* leaving behind the child.

* In my opinion, the said child also died on200..... as a result of I had been
attending her* / and also her said child for providing medical benefit before her / her said child's
death and I attended her for the last time on200.....* and her said child for the last
time.....200...

Date

Signature.....

Insurance Medical Officer

(Rubber stamp or name in block letters)

Any other remarks by the Medical Officer.....

*Notes : *(1) Delete whichever is not applicable.*

*(2) The language may be suitable amended if the Insurance Medical Officer had not
attended the deceased person before her / her child's death.*