Critical Illness Insurance

Claim Form



4' L DETAILO				1 011	od: From	: D [M C	VI I I	YY	Y to	D		101				1 1
ection I - DETAILS (OF INSURED																
ame																	
ddress		F	First Name				Middle	e Name	Э				Sui	rnar	me		
udress																	
	City																
	State						PIN										
	Phone (O)						(R)										
	Fax						Mol	bile									
	E-mail																
	Da	te of Birth	: D D	MM	YYY	Υ			Gei	nder:		Ma	ale			Fem	nale
ection II (To be com	pleted by the C	laimant)							Ma	rital statu	ıs: N	larri	ed			Sing	gle
Disease or condition	on claimed for	•															
First Heart Attack	Total Blir	ndness	Can	ncer (Ex	cluding S	kin Car	icer)		С	oma							
Stroke	Major Bu	irns	Cor	onary A	Artery Su	gery			N	Iultiple S	Scler	osis					
Kidney Failure	Paralysis		Maj	jor Orga	an Transp	lant											
What was the date	of first consul	tation wi	ith a Medi	ical Pra	ctitioner	?					D	D	М	М	Υ	Υ	Υ
What was the date	of first diagno	sis of dis	sease or c	onditio	n ?						D	D	М	М	Υ	Υ	Υ
Name of the hospi	tal and details	of confin	ement for	r this di	sease:					DOA	D	D	М	M	Υ	Υ	Υ
Name of the Hospi	tal									DOD	D	D	M	M	Υ	Υ	Υ
Address																	
	City																
	State						PIN										
	Phone (O)						(R)										
	Fax						Mol	bile									
	E-mail																
Please provide any	details of trea	tment gi	ven for an	ny simil	ar or rela	ted ilin	ess:										
Details of Family D	octor																
Name & Qualification	on																
Address	City																
	State						PIN										
	Phone (R)						Mol	bile									

Se	ection III (To be completed l	y the Attendi	ng Physiciar	n)										
1.	Patient's Name													
2.	Age													
3.	Detailed Diagnosis													
5.6.7.	Type of Symptoms First Date of Symptom Any other disease / medical condition affecting present condition Hospitalisation Details Name & Address of the Hospital	D D M M City State	Y Y Y	Y							PIN			
		Phone								•				
		Date of Admi	ission ·	D M N	ЛҮҮ	YY	Date	e of Dis	charg	e :	D I	ММ	YY	YY
9. Da	Assillness due to any pre-exist Attending Doctor's Name te: DDMMYYY	sting condition	ns:	Yes	No o be sign	ned by th		nature						
rep	ereby authorize any hospital presentative, any and all info pies of all hospital or medical	rmation with r	espect to ar	ny illness	or injury	, medica	l history,	consu	ltation	, preso	cription	ns or	treatm	ent and
Da	te: D D M M Y Y Y	Υ												
Pla	ce:	<u> </u>				Signa	ture of in	sured :						
	yment Mode: Mode selecte oject to the terms and conditi			mpany [·]	to make	payout(s)	to the Pi	ropose	r. Payo	out wo	uld be	in ac	corda	nce and
1)	Name of the Account Hol	der												
2)	Payment Mode		ECS	3	ECS									
3)	Bank Name													
4)	MIRC Code* (Mandatory	for ECS)	IFS(C Code i	s Manda	tory for N	EFT							
5)	Account Type (Tick One)		Sav	ing Acco	ount/Curi	ent Acco	unt							
6)	Full Account Number													
7)	Branch Name and Addres	ss												
ass no inc	cclaimer: I hereby declare the signing any reasons thereof of thold Tata AIG General Insuluding Demand draft/payable digit MICR code of the bank of th	or if the transac urance Co Ltd e at par cheque and branch app	ction is delay responsible e in spite of c pearing on th	ved or no . Further opting Di ne chequ	ot effected r, the Co rect Credue issued	d at all for mpany re lit Option by the ba	reasons serves th nk	of inco he righ	mplete t to us	e/inco	rrect i	inform	nation,	, I would
		Please s	ubmit a bla	nk canc	elled che	que alon	g with th	ne form	1.					
	olicy Holder / Proposer / sured Person Signature		Date D	D M M	I Y Y	YY		Locati	on					
	olicy Holder / Proposer /		Date D	D M M	Y Y	YY		Locati	on					