Chartered Life
Secured Life

CRITICAL ILLNESS CLAIM FORM

POLICY NO:

Notes:
.This form is to be filled in by the person legally entitled for the policy money. All the answer must be clear & unambiguous.
. The benefit is payable subject to policy being in force on the date of event and also subject to fulfillment of all conditions / definitions as stated in the policy.
. Submission of this form should not be construed as acceptance of claim.

PART A: CLAIMANT / INSURED'S STATEMENT

1.INFORMATION ABOUT THE LIFE ASSURED

a. Name of Claimant /Insured		b. Mailing Address:
Age		

2. DOCTORS'S & HOSPITAL DETAILS

a. Name of Attending Physician			
b. Address			
c. Mobile No.		d. Email Address	
e. Name of Clinic /Hospital			f. Address
g. Date of confined to Hospital	From ..... to		

3.SPECIFY WHICH CRITICAL ILLNESS IS APPLICABLE

First Heart Attack , Stroke , Coronary Artery Surgery, Other Serious Coronary Artery Disease, Heart Valve Surgery / Replacement ,Pulmonary Arterial Hypertension, Benign Brain Tumour, Cancer

4. ILLNESS HISTORY

a. Date of first consultation	
b. Date of diagnosis of the disease	
c. Have you ever had the same or similar condition in past	☐ Yes ☐ No

If 'Yes" provide details.

I hereby authorizes all physicians, hospitals, clinics, pharmacists , laboratories, employers and any institution or any other person to disclose to Chartered Life Insurance. Co. Ltd. any and all information with respect to medical history, consultation, prescription or treatments and copies of all hospital or medical records of regarding myself. Any copy of this authorization shall be taken as original.

Claimant's / Insured's Name: _____ Signature: _____

Dated: _____

Witness Name: _____ Witness Signature: _____

Dated: _____ Witness Address & Mobile No: _____

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