Chartered Life

*Secured Life*

# Claim Form

## For Critical Illness Care (CIC)

**(CS Form-17)**

**Policy No** : _____

**Plan & Term** : _____

## PART A : CLAIMANT / INSURED'S STATEMENT

### 1. INFORMATION ABOUT THE LIFE ASSURED

A. Name of Claimant/Insured : _____

B. Mailing Address : _____

C. Mobile Number : _____

### 2. DOCTOR'S & HOSPITAL DETAILS

A. Name of Attending Physician : _____

B. Name of Clinic / Hospital : _____

C. Address : _____

D. Mobile No : _____

E. Email Address : _____

F. Date of confined to Hospital : From : _____ To : _____

### 3. SPECIFY WHICH CRITICAL ILLNESS IS APPLICABLE

1) Stroke, 2) Cancer (excluding Skin Cancer), 3) First Heart Attack, 4) Coronary Artery Surgery, 5) Other Serious Coronary Artery Disease, 6) Heart Valve Surgery / Replacement, 7) Pulmonary Arterial Hypertension (Primary), 8) Benign Brain Tumor, 9) Major Burns, 10) End stage lung disease, 11) Kidney Failure, 12) Surgery to Aorta, 13) Aplastic Anemia, 14) Major Organ Transplant, 15) Loss of Hearing, 16) Loss of Speech, 17) Muscular Dystrophy, 18) Alzheimer's Disease/ Irreversible Organic Degenerative Brain Disorders, 19) Motor Neuron Disease, 20) Parkinson's Disease, 21) Coma, 22) Blindness, 23) Major Head Trauma, 24) Bacterial Meningitis, 25) Paralysis, 26) Corona

### 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 thereby authorize 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: _____ Date : _____

Witness Name : _____

Address : _____

Mobile Number : _____

Signature: _____ Date : _____

Notes: This form is to be filled in by the person legally entitled for the policy money. All the answer must be clear & unambiguous.

## PART B : ATTENDING PHYSICIAN'S STATEMENT

**(All answers must be in the Physician's own hand)**

### 1. HISTORY

**A. Name of patient** : _____ **B. Age :** _____

### C. SPECIFY WHICH CRITICAL ILLNESS IS APPLICABLE

1) Stroke, 2) Cancer (excluding Skin Cancer), 3) First Heart Attack, 4) Coronary Artery Surgery, 5) Other Serious Coronary Artery Disease, 6) Heart Valve Surgery / Replacement, 7) Pulmonary Arterial Hypertension (Primary), 8) Benign Brain Tumor, 9) Major Burns, 10) End stage lung disease, 11) Kidney Failure, 12) Surgery to Aorta, 13) Aplastic Anemia, 14) Major Organ Transplant, 15) Loss of Hearing, 16) Loss of Speech, 17) Muscular Dystrophy, 18) Alzheimer's Disease/ Irreversible Organic Degenerative Brain Disorders, 19) Motor Neuron Disease, 20) Parkinson's Disease, 21) Coma, 22) Blindness, 23) Major Head Trauma, 24) Bacterial Meningitis, 25) Paralysis, 26) Corona

| | | | |
|---|---|---|---|
| **D. Date of appearance of first symptoms** | : | | |
| E. Has the patient ever had the same or similar condition in past? | : | YES ☐ NO ☐ | If "Yes" state when and provide details |
| F. Has disease been caused by AIDS (HIV) | : | YES ☐ NO ☐ | If "Yes" state when and provide details |
| G. Has disease been caused by misuse of Drugs or Alcohol? | : | YES ☐ NO ☐ | If "Yes" state when and provide details |

### 2. PRESENT CONDITION

A. Subjective symptoms : _____

B. Objective findings
(Include results of current X-rays, ECG or any other special Tests:) :

### 3. DIAGNOSIS

**a. Please provide details of diagnosis:**

### 4. TREATMENT

A. Date of first visit : _____ B. Date of last visit : _____

C. Date of last examination : D. Frequency of visits :

### 5. PROGRESS

☐ **Recovered** ☐ **Improved** ☐ **Unimproved** ☐ **Retrogressed**

### 6. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of proceeds there of? Yes ☐ No ☐

### 7. DECLARATION

The above statements are true and complete to the best of my knowledge and nothing therein is false.

Name of Physician : _____ Mobile number : _____

Qualification : _____ Dated : _____

Reg. no : _____ Address : _____

Signature of physician : _____ Official Seal : _____