SUD LIFE

A joint venture of Bank of India | Union Bank of India | Dai-ichi Life

Critical Illness Claim Form

FORM TO BE FILLED BY LIFE ASSURED

Name of the Life Assured:____

Policy Number/s:____

Date of Birth:________________________

Address: ____

BANK DETAILS (Please attach a cancelled cheque)

Bank Name: ________________________________Branch Name _______________________

Bank Account Number: ____

Bank Account Name:____

Bank Account Type: Savings ☐ Current ☐ General ☐

IFSC Code: _________________________________MICR Code:________________________

(Please provide Branch e-mail ID :____)

Critical Illness Condition Claimed:____

A) When did you have symptoms of the condition claimed?

____

B) What was the nature of the symptoms and how long did they last?

____

____

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C) When did you first consult a doctor for these symptoms?
(DD/MM/YYYY)_______________

D) Please provide details of all consultations and investigations done.

Details of Test Done	Date Performed (DD/MM/YYYY)	Findings

(Please attach a copy of all consultation papers, X-Ray reports and investigation done)

E) Do you have a history of diabetes, hypertension, Angina, Vascular Disease, Dyslipidemia or any other medical condition? **Yes / No**

If Yes, please provide following details:

Condition:____

Exact Date of Diagnosis:____________________________________

Duration:____

Treatment taken for same:_________________________________

F) What was the exact diagnosis of your condition as informed by the consulting Doctor?

____

G) What was the treatment given? Was any surgery done?

____

____

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H) Do you smoke, consume Tobacco, or take soft / hard drinks, alcohol, drugs in any form? Yes / No

If Yes, please provide the details along with quantity of daily consumption.

____

I) Please complete the following details with respect to the treatment taken by you

Name of Hospital/s:____

Address:____

Telephone Numbers:____

Date /s of Treatment / Admission (if any):_______________________________

Name of Medical Consultant/s:_______________________________________

Address:____

Telephone Number/s:____

Date of Consultation/s:____

(Please attach copies of all treatment papers, hospital discharge summary, follow-up, reports done, if any)

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J) Please provide any more information pertaining to your health history which may be of assistance to us in faster / speedy processing of your health related illness claim.

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____

Please provide the contact details of Relative / friends (Other than Nominee):

Contact Person Name: ____________________________________

Contact Number: ____

Email ID:____

I, ____declare that the statements made above are true and complete. 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 as known to them either in the past or present to Star Union Dai-ichi Life Insurance Company Ltd and its officers.

Signature of Life Assured:__________________________________

Date and Place:____

Contact No:____

Email ID:____

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