TATA-AIG GENERAL INSURANCE COMPANY LIMITED

Corporate Office: A-501, 5th floor, Building no. 4, Infinity Park,
Gen. A. K. Vaidya Marg, Dindohsi Malad(E)Mumbai - 400 097

CRITICAL ILLNESS CLAIM FORM

IMPORTANT:

1. Please contact our Toll Free no. for registration of claim on Ph: +91-1800 1199 66
2. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
3. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.

Certificate/ Policy No._____________ **Period From** ________________ **to:** ________________

Section I

DETAILS OF INSURED

Name : ____ Phone Nos. _______________________________

Address:__ ____

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Date of Birth: ______/______/_______ Sex: M / F

E-mail id : _______________________

Section II (To be completed by the Claimant)

1. Disease or condition claimed for :

- [ ] Cancer (Excluding Skin Cancer)
- [ ] Stroke resulting in Permanenet Symptoms
- [ ] Kidney Failure Requiring Regular symptoms
- [ ] Permanent Paralysis of Limbs
- [ ] Multiple Sclerosis with persisting symptoms
- [ ] First Heart Attack of specified severity
- [ ] Major Organ / Bone Marrow Transplant
- [ ] Open Heart Replacement ir Reoair of Heart Valves
- [ ] Open Chest CABG

2. What was the date of first consultation with a Medical Practitioner ?
3. What was the date of first diagnosis of disease or condition ?
4. Name of the hospital and details of confinement for this disease DOA:- ____

   Name of the Hospital : ______________________________________ DOD:- ____

   Address : ______________________________________

5. Please provide any details of treatment given for any similar or related illness.:- ____

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6. Details of Family Doctor

   Name & Qualification : ____

   Address : ____

   Tel. No. : ____

7. Details of Specialist consulted in the past and reason for consultation :

   ____

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   ____

8. Details of Domestic Mediclaim Insurance Policy and Claims history , in any :

   ____

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Section III (To be completed by the Attending Physician)

1. Patient's Name : ____________________

2. Age : ____________________

3. Detailed Diagnosis : ____________________

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4. Type of Symptoms : ____________________

5. First Date of Symptom : ____________________

6. Any other disease / medical condition affecting present condition : ____________________

7. Hospitalisation Details : ____________________

Name & Address of the Hospital : ____________________

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Date of Admission : ____________________ Date of Discharge : ____________________

8. Nature of Treatment / Surgical Procedure undergone

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8. Is illness due to any pre-ex conditions : Yes / No ____________________

Attenting Doctor's Name: ____________________

Date: ____________________

Signature: ____________________

Section IV (Authorisation for Release of Medical Information :To be signed by the Insured)

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of insured : ____________________

Date:

Place: