



CRITICAL ILLNESS / TOTAL PERMANENT DISABILITY CLAIM FORM

POLICY DETAILS					
Policy number:					
DETAILS OF LIFE ASSURED					
Name of Life Assured: Mr. N	ls. Mrs.				
Father's / Husband's name:					
Address of Life Assured:					
			PIN Code:		
DETAILS OF THE PERSON INTIMAT	ING THE CLAIM (IF OTH	IER THAN LIFE ASSURED)			
	Ars.	·			
Relationship with Life Assured:					
Address:					
		PIN Code:	Contact number:		
ILLNESS INFORMATION					
Symptoms / Complaints:					
Date of first appearance of symptom	s: D D M M Y	Y Y Y Duration of symptoms / co	mplaints:		
Date of first consultation: D D M M Y Y Y Y Name of consulted doctor:					
Address of consulted doctor:					
		Contact number:	PIN Code:		
Diagnosis:			Diagnosis date: D D M M Y Y Y Y		
What treatment was given?					
Was any operation performed? YES NO If yes, please furnish the details of the surgery:					
DETAIL OF HOODITAL IOATION					
DETAILS OF HOSPITALISATION					
Name of the hospital:					
Hospital address:		law o			
		PIN Code:	Contact number:		
Date of admission:	YYYY	Date of discharge:	MMYYYY		
PAST MEDICAL HISTORY					
		attended / the hospitals where the life as	sured was treated during last five years		
Name of hospital / doctor	Contact details	Date of consultation	Symptoms / Complaints Diagnosis / Tests undergone		
		D D M M Y Y Y Y			
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DETAILS OF FAMILY DOCTOR, IF A	NY				
Name:					
Address:					
		PIN Code:	Contact number:		





IN CASE OF ACCIDENT:					
Date of accident:					
Details of accident:					
EMPLOYMENT DETAILS					
Name of employer:					
Address of employer:					
	PIN Code:				
Date of joining: D D M M Y Y Y Y Last designation held:					
Date of resignation / Last date of work:					
CLAIMANT NEFT MANDATE / BANK ACCOUNT DETAILS					
Bank account no.:					
Account holder name:	IFSC Code (11 Characters)				
Bank name & branch:					
Account type: Savings Current NRO NRE	Account Holder's Name MICR (9 Characters)				
IFSC: MICR: MICR:					
IFSC:					
Please attach relevant records along with this form.					
DECLARATION & AUTHORIZATION					
I do hereby declare that the informatio to the best of my knowledge and belief. I / we understand that in case any of the above information is found	on given on this claim request form is true and complete				
may repudiate the claim amount and take necessary action against me. I hereby authorize any doctor, physic					
treated me for any ailment or illness to divulge any knowledge or information regarding my state of health white was issued by the Company to Generali Central Life Insurance Company Limited and it's authorised represent					
my state of health which such hospital, doctor or laboratory may have acquired before or after the policy w	as issued by Generali Central Life Insurance Company				
Limited. I also authorize my Employer (including any previous employers) to provide information regarding the employment, leave record and medical assistance availed of by me during the tenure of his employment. I further authorize any government organizations /undertakings (including the Police or Revenue) to make					
available to the company or to person or agency as may be authorized by the said company, such information and records as may be needed by it to process a claim.					
I shall not have any objection, in case Company obtains any document pertaining to life assured or me in relat as may be required.	tion to or in respect of the abovesaid Policy or otherwise				
I agree to provide and furnish any other details and reports as and when required by Generali Central Life Insurance Company Limited for processing my claim.					
Sign here	Sign here				
Signature of Witness:	Signature / Thumb impression of Claimant:				
Name of Witness:					
Address:					
PIN Code: Place:	Date: D D M M Y Y Y Y				





DECLADATION TO BE MADE BY THIRD DEDCON FOR THIRM IMPRESSION OF VERNACIII AD SIGNATURE					
The Claimant has affixed his/her thumb impression / has signed in vernacular / has not filled the form. I hereby declare that the content of this form has been explained to the Claimant in language and I have truthfully recorded the answers provided to me. I further declare that the Claimant has signed / affixed his/her thumb impression in my presence.					
Name of the Declarant:					
Address:	I				
Date: D D M M Y Y Y Place:	Sign here				
Date. D D M N N T T T Flace.	Signature of Declarant:				
DOCUMENT CHECKLIST LIST OF REQUIREMENTS: PLEASE TICK () THE DOCUMENTS SUBMITTED					
Original Policy Document					
Attending Physician Statement					
Indoor Case Papers of Present & Past Hospitalisations					
Discharge Summary of Present and Past Hospitalizations					
First Consultation Notes & all Follow- up Consultation Notes					
Certificate of Diagnosis					
All related Medical Examination Reports, e.g.					
Laboratory test reports					
X-Ray / CT scan / MRI Reports & Plates					
Ultrasonography Report					
Histopathology Report					
Clinical / Hospital Reports					
Angiography Reports & Plates					
Others (please specify)					
All the documents submitted to us should be in Original or photocopies attested by a Gazetted Offi¬cer, SEM, Magistrate Talathi, Tahsildar or Police Sub-Inspector or Branch Manager of our company.	All the documents submitted to us should be in Original or photocopies attested by a Gazetted Offi¬cer, SEM, Magistrate or a person of local standing, Sarpanch,				
All medical reports, documents and certification shall be issued by the attending physician and who is qualified to provide such document/certification according to Indian Laws					
In addition to the above documents the Company reserves the rights to ask for more documents/information as may be required in consideration of the claim.					
Notification of claim, submission of claim forms and/or claim documents to the Company shall not be construed as an admission of liabilities of the Company. No					

agent is authorized to admit any liabilities on behalf of the Company, or to alter this list of documents or any claim requirements called for by the Company.