GENERALI Central
LIFE INSURANCE

MEDICAL QUESTIONNAIRE FOR CRITICAL ILLNESS AND TPD RIDERS

(To be filled by the physician who last attended the Insured)

POLICY DETAILS

Policy number: ☐☐☐☐☐☐☐☐

DETAILS OF THE LIFE ASSURED

Name of the Life Assured: ☐ Mr. ☐ Ms. ☐ Mrs. _____

Age: _____ Father's / Husband's name: _____

Gender: ☐ Male ☐ Female ☐ Transgender

DETAILS OF CURRENT ILLNESS

Symptoms / complaints: _____

Duration of symptom / complaint: _____

First consultation for current illness: D D M M Y Y Y Y Last consultation for current illness: D D M M Y Y Y Y

Diagnosis: _____

DETAILS OF HOSPITALIZATION (IF HOSPITALIZED)

Name of the hospital: _____

Address: _____

_____ PIN Code: ☐☐☐☐☐☐

Date of admission: D D M M Y Y Y Y Date of discharge: D D M M Y Y Y Y

PAST MEDICAL HISTORY

Have you treated or given any advice on illness to the deceased, prior to last illness? ☐ YES ☐ NO

If yes, please provide details:

DESCRIPTION	DATE	DURATION OF ILLNESS	DETAILS (DIAGNOSIS, TREATMENT)
1. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		
2. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		
3. Any other consultation / treatment in past 5 years (excluding above)	D D M M Y Y Y Y		

Did the Life Assured, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:

Name of the doctor / hospital	Contact details	Date of consultation	Symptoms / Complaints	Diagnosis / Tests undergone
		D D M M Y Y Y Y		
		D D M M Y Y Y Y		

Note: If you feel that the space provided is insufficient anywhere, kindly attach additional sheets

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IN CASE OF TPD

Is the Life Assured totally disabled? ☐ YES ☐ NO

If yes, please fill the following details:

No.	Particulars	Yes / No	Comments
1	Whether the Life Assured has been rendered totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit	☐ YES ☐ NO	
2	Whether the Insured has suffered the loss of (or the total and permanent loss of use of) both hands, or both feet, or both eyes, or a combination	☐ YES ☐ NO	
3	Whether the above Disability has lasted without any interruption for at least 180 consecutive days?	☐ YES ☐ NO	

IN CASE OF TPD DUE TO ACCIDENT

If the Life Assured totally disabled, is the disability due accident? ☐ YES ☐ NO

If yes, please fill in the following details:

Date of event: D D M M Y Y Y Y

Brief details of event: _____

_____

_____

_____

Documentation of the event (FIR, Medical Reports etc): _____

Date & time of accident: _____

Place of accident (if information available with you): _____

Name of police station where accident was reported, if information available with you: _____

Address of police station where accident was reported, if information available with you: _____

_____ PIN Code: ☐☐☐☐☐☐

Tel. No. of police station where accident was reported, if information available with you: ☐☐☐☐☐☐☐☐☐☐

Any additional information which could help us process the claim (To be filled in by the medical practitioner only)

_____

_____

Please attach related records along with this form.

DECLARATION

I hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Physician's name: _____ Registration no.: _____

Name & address of hospital / clinic: _____

_____ PIN Code: ☐☐☐☐☐☐ Mobile / Telephone number: ☐☐☐☐☐☐☐☐☐☐

Date: D D M M Y Y Y Y

Place: _____

Sign here

Signature

Seal / stamp here

Seal / stamp:

Note: If you feel that the space provided is insufficient anywhere, kindly attach additional sheets