Critical Illness Insurance — Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

IMPORTANT:
1. Issuance of the form is not an admission of liability or a waiver of terms, conditions & exceptions of the insurance contract.
2. Please answer all questions completely. In case of insufficient space, please attach an additional sheet.

Certificate/Policy No. _____ **Period:** From: D D M M Y Y Y Y to: D D M M Y Y Y Y

Section I - DETAILS OF INSURED

Name _____
First Name Middle Name Surname

Address _____

City _____

State _____ PIN _____

Phone (O) _____ (R) _____

Fax _____ Mobile _____

E-mail _____

Date of Birth: D D M M Y Y Y Y Gender: Male ☐ Female ☐

Marital status: Married ☐ Single ☐

Section II (To be completed by the Claimant)

1. Disease or condition claimed for :

First Heart Attack ☐	Total Blindness ☐	Cancer (Excluding Skin Cancer) ☐	Coma ☐
Stroke ☐	Major Burns ☐	Coronary Artery Surgery ☐	Multiple Sclerosis ☐
Kidney Failure ☐	Paralysis ☐	Major Organ Transplant ☐	

2. What was the date of first consultation with a Medical Practitioner ? D D M M Y Y Y Y

3. What was the date of first diagnosis of disease or condition ? D D M M Y Y Y Y

4. Name of the hospital and details of confinement for this disease: DOA D D M M Y Y Y Y

Name of the Hospital _____ DOD D D M M Y Y Y Y

Address _____

City _____

State _____ PIN _____

Phone (O) _____ (R) _____

Fax _____ Mobile _____

E-mail _____

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

6. Details of Family Doctor

Name & Qualification _____

Address _____ City _____

State _____ PIN _____

Phone (R) _____ Mobile _____

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

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

Section III (To be completed by the Attending Physician)

1. Patient's Name
2. Age
3. Detailed Diagnosis
4. Type of Symptoms
5. First Date of Symptom D D M M Y Y Y Y
6. Any other disease / medical condition affecting present condition
7. Hospitalisation Details Name & Address of the Hospital
   City
   State PIN
   Phone
   Date of Admission : D D M M Y Y Y Y Date of Discharge : D D M M Y Y Y Y
8. Nature of Treatment / Surgical Procedure undergone:
9. Is illness due to any pre-existing conditions : Yes No

Attending Doctor's Name

Date: D D M M Y Y Y Y

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.

Date: D D M M Y Y Y Y

Place: Signature of insured :

Payment Mode: Mode selected would be used by the company to make payout(s) to the Proposer. Payout would be in accordance and subject to the terms and conditions of the policy

1)	Name of the Account Holder	
2)	Payment Mode	ECS ECS
3)	Bank Name	
4)	MIRC Code* (Mandatory for ECS)	IFSC Code is Mandatory for NEFT
5)	Account Type (Tick One)	Saving Account/Current Account
6)	Full Account Number	
7)	Branch Name and Address	

Disclaimer: I hereby declare that the particulars given are correct and complete. In case of non credit to my bank account with/without assigning any reasons thereof or if the transaction is delayed or not effected at all for reasons of incomplete / incorrect information, I would not hold Tata AIG General Insurance Co Ltd responsible. Further, the Company reserves the right to use any alternative payout option including Demand draft/payable at par cheque in spite of opting Direct Credit Option.

* 9 digit MICR code of the bank and branch appearing on the cheque issued by the bank

Please submit a blank cancelled cheque along with the form.

Policy Holder / Proposer / Insured Person Signature	Date D D M M Y Y Y Y	Location
Policy Holder / Proposer / Insured Person Signature	Date D D M M Y Y Y Y	Location