

**CLAIM INTIMATION CUM CLAIMANT'S STATEMENT
(CRITICAL ILLNESS RIDER / MAJOR SURGERY ASSISTANCE RIDER)**

(Format : AP)

Guidelines / Notes:

1. The benefit is payable subject to the policy being in force on the date of event and also subject to the fulfillment of all conditions / definitions as stated in the policy.
2. Only the person entitled to receive the policy monies under the Policy should fill & sign this form.
3. Submission of this form should not be construed as acceptance of claim.
4. Please submit the form & the requirements at the nearest branch office or the address given below;
ICICI Prudential Life Insurance Company, Claims Department,
4th Floor, Stanrose House, Appasaheb Marathe Marg, Prabhadevi, Mumbai- 400 025.
5. Early and complete submission of requirements would enable the company to process the claim at the earliest.

Policy Number(s): _____

1. Details of the Life Assured:

Full Name:	Age at Claim:
Current Residential Address:	Tel. No.:
City / Town:	Pin Code: State:

2. Details of the Claimant if different than the Life Assured (To be filled by person entitled to receive claim proceeds under the policy):

Full Name:	Date of Birth / Age:
Current Address:	Tel. No.:
City / Town:	Pin Code: State:
Residential Status:	<input type="checkbox"/> Resident Indian <input type="checkbox"/> Non Resident Indian (NRI) <input type="checkbox"/> Other
If NRI, please state Country of Residence:	
Relationship with the Life Assured:	<input type="checkbox"/> Self <input type="checkbox"/> Other _____
Nature of title to the Policy monies:	<input type="checkbox"/> Proposer <input type="checkbox"/> Assignee

Requirements to be submitted alongwith this form.

(Please Tick)

1. Original Policy Document	<input type="checkbox"/>
2. All consultation notes in connection with the diagnosis of the illness	<input type="checkbox"/>
3. Admission notes and discharge summary from the treating hospital /(s)	<input type="checkbox"/>
4. All test reports such as blood test, X - Ray, ECG, CT Scan and surgery notes	<input type="checkbox"/>
* The following certificates are available at the branch office and should be collected from there:	
5. Certificate by doctor who was consulted first	<input type="checkbox"/>
6. Certificate by treating doctor / hospital	<input type="checkbox"/>
<i>Note: The Company reserves the right to call for additional Documents.</i>	

3. Claim Details:

Cause of claim (Please mention exact nature of illness / surgery):	
Date of diagnosis of critical illness:	
Date of surgery:	

4. Details of Consultations, Diagnosis and Treatments:

What were the symptoms that triggered the need to consult the doctor for the first time in connection with the illness / surgery?	
When were these symptoms first evident and what was the duration?	
Date on which Life Assured consulted the doctor for the first time for the above symptoms:	
Name of the doctor:	
Address:	
City / Town:	Pin code: Tel No:
Name of the tests performed:	
Date on which tests were performed:	
What were the results of these tests?	
Name of the laboratory / clinic / hospital where these tests were carried out:	
Address:	
City / Town:	Pin code: Tel No:
What was the diagnosis made by the doctor?	
What was the treatment given by the doctor and for what duration?	
Was the Life Assured Hospitalized?	<input type="checkbox"/> Y <input type="checkbox"/> N
Date of admission:	
Date and time of surgery:	
Exact name of the surgery:	
Date of discharge:	
Name of the hospital:	
Address:	
City / Town:	Pin code: Tel No:
Diagnosis done by hospital:	

5. Details of Treatment:

Dates of the treatment		Nature of treatment given	Hospital / Clinic Name, address & telephone no.
From	To		

6. Medical History:

Does the Life Assured have any of the following history: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please give details)		
Illness	Date of Diagnosis	Name, address & tel no. of Treating Doctor
Hypertension		
Diabetes		
Heart related ailment		
Kidney disease		
Neurological disease		
Any other (please specify):		

7. Employment Details:

Current employer's business name:		
Address:		
City / Town:	Pin code:	Tel No:
Designation at work place / business:		
Nature of job / business:		
Date of Pre-employment check-up, if any:		
Date of last Annual check-up, if any:		

8. Particulars of other Life Insurance / Mediclaim policies held by the Life Assured:

Policy No.	1	2	3	4
Name of the company:				
Commencement date:				
Sum Assured:				
Riders opted:				
Year of Claim:				
Cause of Claim:				
Amount of Claim:				
Status of the Claim:				

■ I, _____ do hereby declare that the above statements are true in each & every respect. I hereby authorize any medical attendant or doctor who had attended to the above named Life Assured or employer/business associate of the Life Assured to provide any information or details as to the state of health, habits and occupation of the Life Assured, to the Company, within his / her knowledge before or after this policy was issued.

(Signature / Thumb impression of Claimant) Date: _____ Place: _____ Tel No.: _____	Signature of the witness:
	Name of the witness:
	Relationship with the claimant:
	Date: _____ Place: _____ Tel No.: _____

Authorization

(To be signed by the claimant)

To,

Life Insurance Policy Number(s): _____

I, Mr. / Ms. _____ (name), _____ (relation) of Mr. / Ms.

_____ (name of the Life Assured) hereby give my consent to M/s ICICI

Prudential Insurance Co. Ltd., and / or its representative to obtain all employment / medical / hospital records / other records (including photocopies) / information pertaining to the treatment / occupation of the patient.

Yours faithfully,

Signature of the Claimant

Date: