Critical Illness Claims Form : Heart Related Conditions

FORM TO BE FILLED BY LIFE ASSURED

Name of Life Assured:_____

Policy Number :_____

Date of Birth : _____

Address : _____ _____

:_____

A). When did you first have symptoms of heart Disease?

_____

B) What was the nature of the symptoms and how long did they last?

_____

_____

_____

C) When did you first consult a doctor for these symptoms?

_____

D) Please provide details of all consultations and investigations done. (For eg. Dates of ECG/Echo/CTMT/Coronary Angiography/Cardiac Enzyme Test/Thallium Scan etc)

_____

_____

_____

E) Do you have a history of diabetes, hypertension, angina, vascular disease, dyslipidaemia or any other disease? Yes / No

Star Union Dai-ichi Life Insurance Company Limited
Registered Office: Star House, 3rd Floor, West Wing, C-5, G Block, Bandra Kurla Complex, Bandra (E), Mumbai - 400051
Corporate Office: 11th Floor, Vishwaroop IT Park, Sector 30 A, Vashi, Navi Mumbai - 400703.
Toll Free No.: 18002008833 • Tel.: 022-39546300 (Call charges apply, 8.00 am to 8.00 pm)
Email: customercare@sudlife.in • Website: www.sudlife.in • IRDA Regn. No. 142 • C.I.No. U66010MH2007PLC174472

If Yes, please provide the following details:

Condition:_____

Exact date of Diagnnosis:_____

Duration:_____

Treatment taken for the same:_____

F). What was the exact diagnosis of your heart condition as informed by the consulting Doctor?

_____

G) What was the treatment given? Was any surgery done? (For eg. Angioplasty / Heart Valve replacement / CABG / Open Heart Surgery etc). Please provide details with exact dates:

_____

_____

_____

H). Do you smoke or consume tobacco? Yes / No

_____

I). Please complete the following details with respect to the treatment taken by you:

Name of Hospital/s:_____

Address:_____

Telephone Numbers:_____

Date/s of Treatment /Admission (if any):_____

Name of Medical Consultant/s:_____

Address:_____

Tel No/s:_____

Date of Consultation:_____

J). Please provide any more information pertaining to your health history which may be of assistance to us in processing of your claim.

_____

_____

_____

I, _____declare that the statements made above are true and complete. I authorize the medical attendant, hospital; physician who has/have treated or examined me for any ailment or illness to divulge any information regarding my health as known to them either in the past or present to Star Union Daiichi Life Insurance Company and its officers.

Signature of Life Assured:_____

Date and Place:_____

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