# Critical Illness Claim Form

## FORM TO BE FILLED BY LIFE ASSURED

Name of the Life Assured:_____

Policy Number/s:_____

Date of Birth:_____

Address: _____

BANK DETAILS (Please attach a cancelled cheque)

Bank Name: _____Branch Name _____

Bank Account Number: _____

Bank Account Name:_____

Bank Account Type: Savings ☐ Current ☐ General ☐

IFSC Code: _____MICR Code:_____

(Please provide Branch e-mail ID :_____)

Critical Illness Condition Claimed:_____

A) When did you have symptoms of the condition claimed?

_____

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

_____

_____



**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

C) When did you first consult a doctor for these symptoms?
(DD/MM/YYYY)_____

D) Please provide details of all consultations and investigations done.

| Details of Test Done | Date Performed (DD/MM/YYYY) | Findings |
|---|---|---|
| | | |
| | | |
| | | |

(Please attach a copy of all consultation papers, X-Ray reports and investigation done)

E) Do you have a history of diabetes, hypertension, Angina, Vascular Disease, Dyslipidemia or any other medical condition? **Yes / No**

If Yes, please provide following details:

Condition:_____

Exact Date of Diagnosis:_____

Duration:_____

Treatment taken for same:_____

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

_____

G) What was the treatment given? Was any surgery done?

_____

_____



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H) Do you smoke, consume Tobacco, or take soft / hard drinks, alcohol, drugs in any form? Yes / No

If Yes, please provide the details along with quantity of daily consumption.

_____

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:_____

Telephone Number/s:_____

Date of Consultation/s:_____

(Please attach copies of all treatment papers, hospital discharge summary, follow-up, reports done, if any)



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

_____

_____

_____

_____

Please provide the contact details of Relative / friends (Other than Nominee):

Contact Person Name: _____

Contact Number: _____

Email ID:_____

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 Dai-ichi Life Insurance Company Ltd and its officers.

Signature of Life Assured:_____

Date and Place:_____

Contact No:_____

Email ID:_____



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