Critical Illness Claim Form

POLICY NUMBER													

Important instructions:

- The submission of the filled-up claim form, along with the required mandatory documents, is not to be construed as an admission of liabilities of our Company under the policy. No agent/intermediary has been or is authorized to admit any liabilities on behalf of the Company.
- Early submission of this form along with the required mandatory documents, as provided below, will enable us to process your claim faster. PNB MetLife shall not be responsible for any delay in the processing of the claim on account of submission of incomplete claim form and/or non-submission of the mandatory documents.
- This form is to be filled in completely in BLOCK letters.
- Please Counter-sign where amendments/alterations are made in the form.
- Witness signature of a Gazetted Officer/Notary Public/Magistrate or Person of local standing is mandatory.
- Forms & all requirements to be submitted at the nearest branch office of PNB MetLife or the address mentioned above.

Section A: DETAILS OF THE LIFE INSURED

Name: _____ Age: _____

Address (Current Residential Address): _____

_____

City _____ Pin Code _____ State _____

Contact Number: Landline _____ Mobile _____

E-mail Address: _____ PAN No./ Form 60: _____

*Aadhaar No: | X | X | X | X | X | X | X | X | | | | | *Only last 4 digits to be mentioned.

Section B: MEDICAL HISTORY OF LIFE INSURED

Name of Illness/Disease/Injury Sustained: _____

Symptoms: _____

Duration of symptoms: _____ Date of Diagnosis: _____

When were these symptoms first evident/occurred: _____

Date and Time of Admission _____ Date and Time of Discharge _____

Name of hospital: _____

Have you ever had the similar condition in past: ☐ Yes ☐ No (If "yes," provide details) _____

_____

Nature of Illness and Habits	Date of diagnosis of Illness
☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Heart ☐ Cancer ☐ Tuberculosis Other……	
☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs	
If yes, Duration of Consumption _____ & Quantity Consumed _____	
***Note**: Kindly fill additional Doctor's Certificate available for Paralysis, Parkinsons Disease, Stroke, Muscular Dystrophy, Major Head Trauma, and Doctor's Certificate for Neurological condition for Alzheimer's Disease, Deafness, Multiple Sclerosis, Loss of Speech, Loss of Limbs, Motor Neuron Disease, Blindness, Loss of Independent Existence*	

CRITICAL ILLNESS ACKNOWLEDGEMENT SLIP

Policy number(s) _____, _____, _____, _____,
Name of claimant _____
Branch name & code _____
Date: _____ **Employee name & Code** _____

Company Seal & Stamp with Date and time

Documents Submitted:
☐ **Original Policy Document** ☐ **Claimant's photo identity proof** ☐ **Family physician certificate**
☐ **Cancelled cheque / Copy of bank passbook)** ☐ **Attending physician certificate**
☐ **PAN Card/ Form 60** ☐ **Medical Documents (if any)** ☐ **All past medical records for any treatment taken**
☐ **Complete medical records for diagnosis and treatment of the illness diagnosed i.e., all test/investigation reports, discharge summary, indoor case paper**

This acknowledgement slip should not be construed as acceptance of the claim. The Company reserves its right to call additional documents, information and any further requirements necessary in order to decide on processing of the claim.

Information about the Critical Illness (Please tick the illness diagnosed)

☐ Heart attack	☐ Cancer	☐ CABG (Coronary Artery Bypass Surgery)
☐ Stroke	☐ Apallic Syndrome	☐ Benign Brain Tumor
☐ Blindness	☐ Brain Surgery	☐ Coma
☐ End Stage Liver Disease	☐ Heart Valve Surgery	☐ Major Head Trauma
☐ Angioplasty	☐ Major Organ Transplant	☐ Paralysis
☐ Aplastic Anemia	☐ Cardiomyopathy	☐ Deafness
☐ Parkinson's Disease	☐ Poliomyelitis	☐ SLE with Lupus Nephritis
☐ Primary Pulmonary Hypertension	☐ Muscular Dystrophy	☐ Multiple Sclerosis
☐ Motor Neuron Disease	☐ Medullary Cystic Disease	☐ Loss of Speech
☐ Kidney Failure	☐ Alzheimer's Disease	☐ Surgery to Aorta
☐ Major Burns	☐ Terminal Illness	☐ Loss of Limbs
☐ Loss of Independent Existence	☐ Chronic Lung Disease	

Section C: PAYMENT – NEFT

Bank Account no: _____

Name of bank: _____

IFSC code: _____

Section D: DECLARATION & AUTHORIZATION

I do hereby declare that all the above statements are true and complete and that nothing has been suppressed or with - held from my side. I understand that in furnishing claim form PNB MetLife has not admitted liability or waived any of its rights under the policy. I hereby authorize the physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information or furnish the records regarding my state of health which he/they may have acquired whether before or after the policy was issued by PNB MetLife.

I/We hereby further consent, and authorize, PNB MetLife to use and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this statement or obtained otherwise) which may include KYC documents to any individual / organisation / entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry association / federations, for the purpose of processing this claim and/or for providing subsequent service.

Signature/Left Thumb impression _____ Date _____

Declaration by the person filling in the Critical Illness Claim form. (in case the Critical Illness Claim form is filled up / signed in a language different from that of application form)

I hereby declare that I have fully explained the contents of the Critical Illness Claim form to the claimant in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the claimant and the replies have been read out to, fully understood and confirmed the claimant.

The content of the form and document have been fully explained to me and that I have fully understood the content mentioned herein and its significance for the proposed Claim

Date	Place	Signature of Declarant/ Witness	Signature / Left thumb Impression Claimant/ Nominee

Name of Declarant/ Witness: _____ Address of Declarant/ Witness: _____

Contact No. of Declarant/ Witness: _____ Claimant relation with Declarant/ Witness: _____

Date: _____ Place: _____

Mandatory Documents to be submitted along with this form:

- Doctor's Certificate (From the family physician or treating doctor) preferably in the standardized PNB MetLife format
- Discharge Summary confirming the surgery undergone
- All past medical records for any treatment taken
- Cancelled cheque / Copy of bank passbook
- PAN Card/ Form 60 of the life assured
- Current address proof
- Photo identity proof
- Hospital Cash Benefit Claim Form to be attested by concerned doctor
- Authorization letter from the claimant in case the claim intimation is received through third party for claims received at the Branch/ GPH

Note: Please mask first 8 digits of Aadhaar number if Aadhaar Card is submitted as KYC proof with the request