

## Critical Illness Claim Form

<b>POLICY NUMBER</b>																			
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**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: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td></td><td></td><td></td><td></td> </tr> </table>	X	X	X	X	X	X	X	X	X				
X	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: <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes," provide details) _____ _____	

Nature of Illness and Habits	Date of diagnosis of Illness
<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> IHD <input type="checkbox"/> Malignancy Other.....	
<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs If yes, Duration of Consumption _____ & Quantity Consumed _____	

**CRITICAL ILLNESS ACKNOWLEDGEMENT SLIP**

Policy number(s) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Name of claimant \_\_\_\_\_

Branch name & code \_\_\_\_\_

Date: \_\_\_\_\_ Employee name & Code \_\_\_\_\_

Documents:      Original Policy Document      Claimant's photo identity proof      Family physician certificate

Submitted:      Cancelled cheque / Copy of bank passbook)      Attending physician certificate

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

**Company Seal & Stamp with Date and time**

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)

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Cancer	<input type="checkbox"/> CABG (Coronary Artery Bypass Surgery)
<input type="checkbox"/> Stroke	<input type="checkbox"/> Apallic Syndrome	<input type="checkbox"/> Benign Brain Tumor
<input type="checkbox"/> Blindness	<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> Coma
<input type="checkbox"/> End Stage Liver Disease	<input type="checkbox"/> Heart Valve Surgery	<input type="checkbox"/> Major Head Trauma
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Major Organ Transplant	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Aplastic Anemia	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Deafness
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Poliomyelitis	<input type="checkbox"/> SLE with Lupus Nephritis
<input type="checkbox"/> Primary Pulmonary Hypertension	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Motor Neuron Disease	<input type="checkbox"/> Medullary Cystic Disease	<input type="checkbox"/> Loss of Speech
<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Surgery to Aorta
<input type="checkbox"/> Major Burns	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Loss of Limbs
<input type="checkbox"/> Loss of Independent Existence	<input type="checkbox"/> 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 he reby furtherconsent,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 pro- cessing 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	Signature / Left thumb Impression Claimant/ Nominee

Name of Witness: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_

Address of Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_

<p><b>Documents to be submitted along with this form:</b></p> <ul style="list-style-type: none"><li>• Original policy document</li><li>• Family physician certificate</li><li>• Attending physician certificate</li><li>• Complete medical records for diagnosis and treatment of the illness diagnosed i.e. all test/investigation reports, discharge summary, indoor case papers</li><li>• All past medical records for any treatment taken</li><li>• Cancelled cheque</li><li>• Id &amp; residence proof</li></ul>
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