Claim Form for Staged Critishield Benefit

Questionnaire to be completed by the specialist who treated the life insured for illness

Policy Number: | | | | | | | | | | |

Date: D D M M Y Y Y Y

Benefit Type: Cardiac ☐ Renal ☐

1. Personal details of the Patient Life Insured:

Name: _____

Address of Life Insured: _____

_____

Date of Birth: D D M M Y Y Y Y Age: | |

2. Details of Hospitalization / Treatment:

Name: _____

Address: _____

_____

Tel. No. of Referring doctor: | | | | | | | | | | Date of Admission / Consultation: D D M M Y Y Y Y

Date of Discharge: D D M M Y Y Y Y

3. History reported at the time of admission / Consultation:

Symptoms	**Nature of Symptom**	**Since when / Duration(months / years)**
Illnesses / Other Conditions	**Nature of Condition**	**Date of Diagnosis**
Name, Tel No. & Address of Doctor who diagnosed of the above		
Surgeries done in the past	**Name of the Surgery**	**Date of Surgery**
Name of the Hospital where surgery was performed		
Habits such as smoking / drinking (quantity & duration)		

FOR/11/17-18/1247

Details of Family History	
History was given by	Life Insured / Family / Others. If Others: Name: _____ Address: _____ _____ Contact No.: ☐☐☐☐☐☐☐☐☐☐ Relationship with the Life Insured: _____ Name of the person who recorded the history: _____

4. Details of Diagnoses made by you / your hospital:

Provisional diagnosis	
Tests done and results of the same for confirming the diagnosis	
Final diagnosis	
Treatment given	
Duration of the treatment	

5. Had the patient been admitted or treated by you or your hospital earlier? If yes, Please provide the following details:

Date		In – Patient / Out - Patient	Reason for seeking treatment	Treatment Given
From	**To**			

Name of the Doctor: _____

Registration no of the Doctor: _____

Address: _____

_____

Telephone No.: ☐☐☐☐☐☐☐☐☐☐ Mobile No.: ☐☐☐☐☐☐☐☐☐☐

Email Id: _____

Signature & Seal: _____ Place: _____ Date: D D M M Y Y Y Y

Declaration:

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy. Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned address.