MEDICAL QUESTIONNAIRE FOR CRITICAL ILLNESS CLAIM

(To be filled by the physician who last attended the Insured)

Details of the Life Assured

Full name of the Life Assured	
Age & Gender	
How long have you known the Life Assured	
Date(s) of previous consultation	
Diagnosis & Treatment given	

Details of Current Illness
(A)

Symptoms/Complaints	
Duration of Symptom/ Complaint	
Date of First Consultation	
Diagnosis	
Diagnosis Date	

(B) Details of Hospitalization (if hospitalized)

Name of the Hospital			
Address			
Date of Admission		Date of Discharge	
Details of registration of Hospital			
No. of other doctors working in the Hospital (approx)			

(C) Did the Life Assured, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:

Name of Doctor/Hospital	Address	Date of Consultation	Diagnosis

Please attach records alongwith this form.

I hereby declare that the information provided above is best to my personal knowledge & belief and nothing has been concealed there from.

Name: _____ **Signature & Seal:** _____

Registration No:_____ **Date:** _____