GENERALI Central
LIFE INSURANCE

REQUEST FOR CRITICAL ILLNESS CLAIM

(To be filled in by person legally entitled to the claim amount)

Please answer all questions, use "not applicable" (N/A) as appropriate. Do not leave any question blank. Counter-sign where amendments/alterations are made in the replies in the form. The filling of this form is not to be construed as an admission of liability on the part of Generali Central Life Insurance Company Limited (the " Company'') No agent has been or is authorized to admit any liability on behalf of the Company.

DETAILS OF THE LIFE ASSURED			
Full Name			
Correspondence Address and Contact No.			
Bank Account No.		Type of Account	
Name as appearing in the Bank Account			
Bank Name & Branch			
Employer Name & Address			

DETAILS OF ILLNESS	
Symptoms/Complaints	
Duration of Symptom/ Complaint	
Date of First Consultation	
Name & Address of Doctor Consulted	
Diagnosis	
Diagnosis Date	

DETAILS OF FAMILY DOCTOR	
Name of the Doctor	
Address	
Contact Nos.	

NAME AND ADDRESS OF THE DOCTORS WHO HAD ATTENDED / THE HOSPITALS WHERE THE LIFE ASSURED WAS TREATED DURING LAST FIVE YEARS

Name of Doctor/Hospital	Address	Date of Consultation	Diagnosis

DECLARATION & AUTHORISATION

I _____ do hereby declare that the information given on this claim request form is true and complete to the best of my knowledge and belief. I/we understand that in case any of the above information is found to be false or fabricated, the Company at its discretion may repudiate the claim amount and take necessary action against me.

I hereby authorize any doctor, physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information regarding my state of health which may have acquired whether before or after the policy was issued by the Company to Generali Central Life Insurance Company Limited and it's authorised representatives/claims investigators such information regarding my state of health which such hospital, doctor or laboratory may have acquired before or after the policy was issued by Generali Central Life Insurance Company Limited. I also authorize my Employer (including any previous employers) to provide information regarding the employment, leave record and medical assistance availed of by me during the tenure of his employment. I further authorize any government organizations /undertakings (including the Police or Revenue) to make available to the company or to person or agency as may be authorized by the said company, such information and records as may be needed by it to process a claim. I shall not have any objection, in case Company obtains any document pertaining to life assured or me in relation to or in respect of the abovesaid Policy or otherwise as may be required.

DECLARATION & AUTHORISATION

I agree to provide and furnish any other details and reports as and when required by Generali Central Life Insurance Company Limited for processing my claim.

Signature of Witness

Signature/Thumb Impression of Claimant

Name of witness

Place

Address

Date

VERNACULAR DECLARATION

If the Claimant signs in vernacular or affixes a thumb impression, the witness should also sign the following:

I certify that the contents of this form were explained to the Claimant in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Signature

Address

Full Name

Contact Nos.

Designation

Note: This declaration must be witnessed by any one of the following Employer, Advocate, Bank Manager, Officer, Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body of Branch Manager of our Company

LIST OF REQUIREMENTS: PLEASE TICK (✓) THE DOCUMENTS SUBMITTED

- ☐ Original Policy Document
- ☐ Attending Physician Statement
- ☐ Indoor Case Papers of Present & Past Hospitalisations
- ☐ Discharge Summary of Present and Past Hospitalizations
- ☐ First Consultation Notes & all Follow- up Consultation Notes
- ☐ Certificate of Diagnosis
- ☐ All related Medical Examination Reports, e.g.
  - Laboratory test reports
  - X-Ray/ CT Scan/ MRI Reports & Plates
  - Ultrasonography Report
  - Histopathology Report
  - Clinical / Hospital Reports
  - Angiography Reports & Plates
  - Others (please specify

- All the documents submitted to us should be in Original or photocopies attested by a Gazetted Officer, SEM, Magistrate or a person of local standing, Sarpanch, Talathi, Tahsildar or Police Sub-Inspector or Branch Manager of our company.
- All medical reports, documents and certification shall be issued by the attending physician and who is qualified to provide such document/certification according to Indian Laws
- In addition to the above documents the Company reserves the rights to ask for more documents/information as may be required in consideration of the claim.
- Notification of claim, submission of claim forms and/or claim documents to the Company shall not be construed as an admission of liabilities of the Company. No agent is authorized to admit any liabilities on behalf of the Company, or to alter this list of documents or any claim requirements called for by the Company.