



jeevan suraksha ka
naya nazariya

Bharti AXA Life Insurance Company Limited
Unit No. 601 & 602, 6th floor, Raheja Titanium, Off Western Express Highway,
Goregaon (East), Mumbai - 400 063. www.bharti-axalife.com
Toll Free: 1800-102-4444

CRITICAL ILLNESS CLAIMANT'S STATEMENT

(To be completed by the Claimant)

No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Policy No	Name of Life Insured	Name of Claimant	Current Residential Address & Contact No. of Claimant

Requirements to be submitted along with this form.

Critical Illness Claims Requirements	Please Tick whichever documents you have submitted
1. Original Policy Kit	
2. Copies of Medical Records, Test Reports, Discharge summary, Admission records of hospitals and indoor case papers	
3. CI Rider Claimant's Statement.	
4. Copy of bank passbook / bank statement.	
5. Copy of Address Proof.	
6. CI Attending Doctor's Certificate	
7. Hospital Treatment Certificate	
8. Treating Doctor's Certificate	
9. Family Physician Certificate	

Note: The Company reserves the right to call for additional requirements, if needed

1. Information on the Critical Illness

(a) Name of Critical Illness:

(b) Symptoms:

.....

(c) Date of onset of symptoms: Date of diagnosis:

(d) Present condition of illness:

2. Details of Consultations and Treatment in respect of the critical illness

Date	Name of the doctor / medical practitioner	Address / Contact Details	Diagnosis

3. Name and address of the Life Insured's usual Doctor.

Name	Address

4. Details of hospitalizations of the Life Insured, if any, for the critical illness or any other illness in the last 5 years:

Name and Address of Hospital or Institution	Date Admission	of	Date Discharge	of	Diagnosis

5. Have any of the Life Insured's family members suffered from a similar illness? If 'Yes', please provide details.

Relationship of the family member with the member	Nature of Illness	Date it was first diagnosed

6. Does the Life Insured consume alcohol or use tobacco in any form? If 'Yes', please provide details below:
- (a) Alcohol: (i) Nature of substance consumed.....
(ii)Duration and quantity of consumption.....
- (b) Smoking / use of tobacco: (i) Nature of tobacco abuse
(ii) Duration and quantity of consumption.....

7. Is the Life Insured eligible for similar benefits with any other insurance company? If yes, please provide details

Name of the Insurance Company	Amount of Benefit Sum Assured	Has a claim been submitted in connection with this illness

Declaration and Authorization:

I/We do hereby declare that all the statements and answers to all questions given by me above are to the best of my knowledge and belief, correct, complete and true.

I/We authorize any doctor / hospital / laboratory / institution / past and present employer(s)/business associates/any life and non-life insurance company/organization or the Life Insurance Association's medical register to provide any knowledge or information concerning the life insured's health, habits or employment to the Company.

Signature of Claimant	Date

Name of Witness	Signature of Witness

