

## WITHOUT PREJUDICE

## **CRITICAL ILLNESS CLAIM FORM FILLED BY DOCTOR**

(TO BE FILLED BY THE DOCTOR)

Policy Number(s):

f. Angiography Report

g. Any other test/surgery (please specify)

Name of the Life Assured:		
Date of Birth: DDMMMYYYYYOCcupation: DOCCUPATION:		
Address:		
		Post Code:
Please complete the following details: - (If space provided in the box is inadequate, kindly attach annexure.)		
1. Are you the patient's usual doctor? If yes, how long had you known the Patient?		
2. Date of onset of the condition: DDDMMMYYYYY		
3. What is the present stage of Critical Illness?		
4. Details of diagnosis;		
5. Please give the following details of the tests conducted during the investigations:		
Investigation and Surgery	Date on which Performed	Results
a. ECG		
b. X – Ray		
c. Sonography/CT Scan/MRI		
d. Biopsy / FNAC / PAP smear		
e. Blood Report		

Kindly submit the original reports of the above investigations and Histopathology Reports/IHC Operating Surgeon's report, Consultant's reports, all blood test reports, Hospital discharge summary, all follow up reports and any other reports available with you to our Senior Medical Officer. The reports will be returned to you promptly.

SBI Life Insurance Company Limited: Registered and Corporate Office: Natraj, M.V. Road & Western Express Highway Junction, Andheri(East), Mumbai- 400 069. Tel.: (022) 61910000. Central Processing Center: 7th Level (D-Wing) & 8th Level, Seawoods Grand Central, Tower 2, Plot No. R-1, Sector-40, Seawoods, Nerul Node, Navi Mumbai- 400 706. Tel.: (022) 66456000. IRDAI Registration No. 111. CIN: L99999MH2000PLC129113. Toll Free No. 1800 267 9090 (Customer Service timing: 24X7). Visit: www.sbiilife.co.in E-mail: info@sbiilife.co.in



6. Has there been any previous disease or other conditions:			
7.a Date of Commencement of Treatment:			
7.b Details of Treatment / Surgery:			
8. Name and Address of the Hospital where the surgery was performed			
8.a Hospital Details :			
Name of the Hospital:			
Address:			
Telephone Number:			
I.P.No. : Date of Admission: D D M	M Y Y Y Y Date of Discharge: D D M M Y Y Y Y		
8.b Operating Surgeon Details			
Name of the Operating Surgeon:			
Address:			
Tolophone Number			
Telephone Number:			
8.c Any Specialist/Hospital referred:			
Name of the Specialist/Hospital:			
Address:			
Telephone Number:			
9. Additional Information			
Address of the Hospital :			
Circumstative of Madical Attachded and Hamital Charge			
Signature of Medical Attendant and Hospital Stamp			
Registration No:	Place:		
Qualification:	Date: D D M M Y Y Y Y		
Designation: Telephone No.:			

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