

Please specify details of the operating surgeon, if any surgery has been performed:

Name:

Address:

Telephone Number:

Name and address of the Hospital he/she is attached:

Telephone Number of the Hospital:

I.P. No. : Date of Admission: Date of Discharge :

PART 4 – INFORMATION ON OTHER INSURANCE POLICIES

A. Policy Number/s:

Sum Assured: ₹

Insurance Company Name:

B. Policy Number/s:

Sum Assured: ₹

Insurance Company Name:

PART 5 – DOCUMENTS

Please provide the following documents in original/Xerox Copies attested by the hospital

- Original Certificate of Insurance
- All consultation notes in connection with the diagnosis of the illness
- Admission notes and discharge summary from the treating hospital /s
- All test reports such as blood test, X – Ray, ECG, CT scan and surgery notes
- Certificate by treating doctor / hospital

Note: The Company reserves the right to call for additional documents

PART 6 – DECLARATION

Note – In the event the Life Assured with Illness is unable to complete this form, ignore Part 6. Part 7 should be completed.

I, _____, do hereby declare that this statement made here in above is true in each and every respect.

I authorize the Hospital/s and Doctor/s, who have examined or treated me for any ailment or illness and my Employer or its officers or any other person to provide information regarding the Illness which they may have acquired before or after the policy was issued by SBI Life Insurance Co. Ltd., to the Company and its officers.

I agree to provide and furnish details and reports as and when required by SBI Life Insurance Co. Ltd. for processing this critical illness claim.

<div style="border: 1px solid black; width: 100%; height: 80px; margin-bottom: 5px;"></div> (Signature / Thumb Impression of Life Assured)	Signature of the witness: <div style="border: 1px solid black; width: 100%; height: 50px; display: inline-block;"></div> Name of the witness: _____ Relationship with the Life Assured: _____
Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Place : _____ Telephone No. : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Place : _____ Telephone No. : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

This declaration must be witnessed by an Advocate, Bank Manager, Block Development Officer, Commissioner of Oaths/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 or SBI Life officers above Asst. Manager designation.

If the declarant 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 Life Assured in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Date:

Signature of Witness

PART 7 – DECLARATION

Note – This should only be completed if the Life Assured with illness is unable to complete this form.

I, _____, do hereby declare that this statement made here in above is true in each and every respect.

On behalf of _____ (the Life Assured), I authorise the Hospital and Doctor/s who have examined or treated _____ (the Life Assured) for any ailment or illness and his/her Employer and its officers or any other person to provide information regarding the Illness which they may have acquired before or after the policy was issued by SBI Life Insurance Co. Ltd., to the Company and its officers.

On behalf of _____ (the Life Assured), I agree to provide and furnish details and reports as and when required by SBI Life Insurance Co. Ltd. for processing this critical illness claim.

<div style="border: 1px solid black; height: 70px; width: 100%;"></div> <p>(Signature / Thumb Impression of Life Assured)</p>	<p>Signature of the witness: <div style="border: 1px solid black; height: 50px; width: 100%;"></div></p> <p>Name of the witness: _____</p> <p>Relationship with the Life Assured: _____</p>
<p>Date : <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/></p> <p>Place : _____</p> <p>Telephone No. : <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p>	<p>Date : <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/></p> <p>Place : _____</p> <p>Telephone No. : <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p>

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If the declarant 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 Life Assured in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Date:

Signature of Witness

