Critical Illness Claim Form
Sample - Stroke Patient

Note: This is a sample template for a signed critical illness insurance claim, customized for stroke patients.

Personal Information

Full Name of Patient

John Doe

Date of Birth

1965-08-15

Policy Number

CI-1234567890

Residential Address

123 Health Avenue, Suite 400, Med City

Contact Number

+1 234 567 8900

Illness Details

Diagnosis

Stroke (Ischemic)

Date First Diagnosed

2023-01-12

Hospital/Clinic Name

City General Hospital

Name of Attending Physician

Dr. Emily Carter

Brief Description of Symptoms and Progression

Sudden weakness on right side, speech difficulties, facial droop noticed on 2023-01-12. CT scan confirmed ischemic stroke. Underwent acute care and rehabilitation.

Medical History

Relevant Medical History

Hypertension and high cholesterol diagnosed in 2017. No prior stroke or major illness.

Declaration and Signature

I hereby declare that the information provided in this critical illness claim form is accurate and complete to the best of my knowledge. I authorize the release of all medical records and information pertinent to this claim to the insurance provider.

Signature of Patient/Representative

_____

Date Signed

2024-06-15

For a downloadable version, please contact your insurance provider or visit their official website.