Critical Illness Benefit Claim Form
with Doctor's Attestation

Section 1: Policyholder/Claimant Information

Full Name:

Enter your full name

Policy Number:

Enter your policy number

Date of Birth:

Contact Number:

Enter your contact number

Address:

Enter your complete address

Section 2: Illness Details

Diagnosis of Critical Illness:

State diagnosed critical illness

Date Diagnosed:

Date Symptoms First Appeared:

Treatment Details:

Describe treatment, hospital details, etc.

Section 3: Supporting Documents

- Copy of Diagnosis Report

- Medical Certificates
- Discharge Summary (if hospitalized)
- Relevant Lab/Imaging Reports

Section 4: Declaration by Claimant

I, Full Name , hereby declare that the information given above is true and correct to the best of my knowledge. I authorize the insurance company to obtain medical information from my attending doctor(s) if required for claim assessment.

Signature:

Sign here

Date:

Section 5: Doctor's Attestation

I certify that I have personally examined and treated the above-named patient and confirm that the information regarding diagnosis and treatment provided is accurate and corresponds to my medical records.

Doctor's Name:

Enter doctor's full name

Qualification:

Enter qualifications

Medical Registration Number:

Enter registration number

Hospital/Clinic Name:

Enter hospital/clinic name

Doctor's Signature:

Doctor's signature

Date:

Note: This is a sample template for reference. Actual forms may require additional information as per insurer's guidelines.