F. No. AC – 39

The New India Assurance Company Limited

Regd. & Head Office : 87, Mahatma Gandhi Road, Fort, Mumbai - 400 001.

Critical Care Illness Insurance Claim Form

The Issue of this form is not to be taken as an admission of Liability

TO BE COMPLETED BY THE INSURED

. **DETAILS OF INSURED CLAIMANT**

(a) Name of the insured [in full]

(b) Address in full

(c) Telephone no.

(d) Place of domicile

(e) Profession or occupation

(f) Age at last birthday

(g) Date and Serial no of Norka ID Card

(h) Passport No.

INFORMATION OF ILLNESS

. (a) Illness/ Disease diagnosed

(b) Date and Place of Diagnosis

(c) Medical Attendant's Name and Address
with Telephone no.

(d) Treatment details with hospitalisation if any

(e) Present state of illness / disease

DOCUMENTS REQUIRED ALONG WITH THE CLAIM FORM

(a) Copy of Norka ID Card
(b) Copy of Passport
(c) Information and reports pertaining to the concerned illness / disease

I hereby declare that the foregoing statements are made by myself and are true in all respect and that I have not attempted to conceal from the Company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than

absolutely necessary and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited and I am willing, if required to make a Statutory Declaration before a Justice of the Peace of the truth of the whole of the foregoing statement or any other statement I may make in connection with this claim.

Attestation of Norka Signatory
Name_______________________________ Signature of the Insured________________
Signature____________________________ Date-
Address__________________________ Place-

MEDICAL CERTIFICATE

Claims must be Supported by medical Evidence furnished by the Insured and at his expense.

1. (a) Name of Claimant
   (b) Sex (c) Age

2. Nature and cause of illness/ disease

3. Is Claimant suffering from any other disease or illness apart and is there any illness by circumstances? If so, give particulars ?

4. Present condition

5. How long has the patient been suffering from the disease

Having personally examined the above named Insured I Certify that the above statements are correct and true to my knowledge

Date Name & Qualification

Registration No. Address

MEDICAL CERTIFICATE

(To be printed in the letter head of the hospital or that of the consulting doctor)

To Whomsoever it may concern

This is to certify that I have examined Mr/Ms
____

(IP/OP No.___________________) on ___________________ at
_________________________________.

The following tests have been done for diagnosis and confirmation of listed Critical illness :

1.
2
3

On the basis of my consultations and tests conducted, I hereby confirm that he/she is suffering from a **critical medical condition** and has been diagnosed with the following critical ailment/ illness ______________________ and that the patient is affected severely by the same illness with typical clinical history and symptoms of a specified severity of _______________ (stage /Grade of illness)

I also confirm that he/she requires prolonged treatment of _____________________ (cycle/course and duration of Treatment) as given in the various medical records.

NAME SIGNATURE AND SEAL   DATE

OF THE SPECIALIST MEDICAL PRACTIONER