Regd. Office: Bombay Pune Road, Akrudi, Pune 411 035 & Head Office: GESCO Plaza, Airport Road, Yerawada, Pune 411 006

CRITICAL ILLNESS COVER

Claimant's Statement

Claim No (TO BE GIVEN BY BAGICL)

1	Name of the Insured	:	
2	Policy Number	:	
3	Residential Address	:	
4	Home telephone number	:	
	Business telephone number		
5	Present completed age	:	
6	Occupation at the onset of your illness	:	
	Please describe activities/duties of your job		
7	Please give details of extent and nature of your current illness	:	
8	Date on which you first consulted a doctor for this illness	:	
9	Have you previously from or received any treatment for a related illness? Yes/No if yes, give complete details	:	
10	Please give details of the treatment you have received including dates of out patient or inpatient treatment	:	
11	Have any of your blood relatives suffered from similar or related illness? If yes, give details of when it was initially diagnosed	:	
12	Do you smoke Cigarettes? Yes /No	:	
13	Please give the name, address and phone number of your family physician	:	
14	Please give names, addresses and telephone numbers of all physicians who have treated you and of all hospitals at which you have been treated for this illness (include dates attended) (format Below)	:	

Name (Specialty)	Address	Telephone Numbers

In support of the above claim, I enclose following documents (Please indicate by tick mark)

1. Discharge certificate/Discharge card from the Hospital
2. Specialist's certificate confirming the diagnosis with supporting pathological, imaging or any other reports
3. Surgeon's certificate stating nature of operation performed with detailed operative notes
4. Details of the anesthesiologist's report with pre operative, operative and post operative comments

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme of insurance. **I consent and authorize the Bajaj Allianz General Insurance Company or their representatives** to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

Date :

Signature of the Claimant