Punjab Life
Insurance Company Limited

PUNJAB LIFE INSURANCE COMPANY LIMITED (PLIC)
CLAIM FORM - CRITICAL ILLNESS (CI)

1. This Form contains three (3) Sections. Each section should be filled separately by **Participant, Medical Attendant & Employer**. This form should be filled by the Participant/Claimant under Critical Illness Claim.

2. All persons are required to give correct & complete information. The Company is entitled not to entertain any claim if this claim form is not completed in full & accurately.

3. Acceptance of this form does not mean admission of liability by the Company.

PART 1 – POLICY HOLDER / PARTICIPANT'S STATEMENT:

1. Covered Person's / Participant's Details:			
Name of Covered Person / Participant			
CNIC No.		Date of Birth	____ / ____ / _____
Age		Sex	☐ Male ☐ Female
Occupation		Telephone No.	
Address			
Bank Account No., Name & Branch			

2. Critical Illness Details:			
Name of Disease		Date of Diagnosis	____ / ____ / _____
Hospital Name		Name of Doctor	
Date of Onset of Symptoms	____ / ____ / _____	Date of Onset of Disease	____ / ____ / _____
Age at Onset			

Date(s) of Confinement at Home:

Date From	Date To	Treatment Provided

Punjab Life
Insurance Company Limited

Date(s) of Confinement at Hospital:			
Hospital Name	**Date From**	**Date To**	**Treatment Provided**

3. In Case of Surgery — Place of Surgery / Hospital Date & Time:			
Hospital Name	**Dr. Name**	**Date From — Date To**	**Reason of Surgery**

4. Declaration by the Policy Holder / Participant:

I _____ as the Policy Holder / Participant/Claimant do hereby declare that all foregoing answers & information stated above are complete and true to the best of my knowledge & belief & I have not concealed any important details from this Company. I hereby claim Critical Illness benefits & agree that all information disclosed by the Doctors treating me & all documents provided to support this claim is proof of it. Further, I agree that this form & other additional related documents & investigations or examinations by the Company cannot be interpreted or assumed as admission of liability by the Company, & is not proof of any agreement which takes effect on the said person or discharge of any right or defense by the Company. I hereby give consent to doctors or related parties of hospitals etc. to disclose to the Company any explanation or information which is deemed necessary with regards to the diagnosed person. I hereby declare that I am suffering from covered Critical Illness as mentioned above.

Signature of Policy Holder / Participant:	**Signature of Witness:**
Date:	**Name:**
Place:	**Address:**

Please attach the original documents of the following:

1) Copy of CNIC of Claimant

2) Medical History / Record

3) Doctor Advice

4) Hospitalization Record

5) Hospital Discharge Certificate / Summary

6) Prescriptions

Punjab Life
Insurance Company Limited

PART 2 – MEDICAL ATTENDANCE STATEMENT:

1. Medical Attendant Detail:			
Name of Doctor		PMDC No.	
Name of Hospital / Address			
Specialty		Telephone No.	
Is person covered related to you? If yes, please give details			
Date of First Visit & details of complaints			
Date of Last Visit	____ / ____ / _____	Diagnosis	
Cause of Disability			

2. Other Information:	
Past history of the disease	
Since how long the patient was suffering from the disease	
Please specify any other information which is pertinent	
Details of Complaints, Investigation & treatment during last 3 years	
In your opinion, is disability suffered considered to be total and permanent in nature, preventing the person covered from ever again following his/her own occupation or any occupation which he/she is reasonably suited by reason of education, training or experience, and which has persisted for at least six (6) months?	

3. Declaration by the Medical Attendant:
I _____ medical attendant of the below named person _____ do hereby solemnly declare that all foregoing answers and information stated above are complete and true to the best of my knowledge and belief and I have not concealed any details from this Company, which are necessary with regards to the above.

Signature of Doctor with Stamp:	Signature of Witness:
Date:	Name:
Place:	Address:

PART 3 – EMPLOYER'S DETAILS:

1. Details of the Employer:			
Name of Employer		Telephone No.	
Address of Employer		Email	
Date of Appointment / Account Open of Covered Person			

2. Declaration by the Authorized Person of the Company:
I _____ employer of the below named person covered _____ do hereby solemnly declare that all foregoing answers and information stated above are complete and true to the best of my knowledge and belief and I have not concealed any details from this Company, which are necessary with regards to the above. I hereby declare that he/she is suffering from Total and Permanent Disability and unable to follow his/her own occupation or any other occupation reasonably suited to him/her as per his/her education and experience.

Authorized Signature with Stamp:	**Signature of Witness:**
Date:	**Name:**
Place:	**Address:**