La Capitale

CLAIM FOR CHILDREN'S CRITICAL ILLNESS BENEFITS
Claimant's Declaration

- This form must be duly completed by the father, mother or legal guardian if the insured child is a minor.
- The Insurer reserves the right to require any additional information it deems necessary.
- The Insurer assumes no liability for any expenses incurred in providing the proof required for claims.

Information about insured

Name and address of the insured: ______________________________

____

Postal Code

Tel.: (_______)______________________________
Home

Gender: F ☐ M ☐

Date of Birth: _________-__________-__________
Year Month Day

Contract No.: ______________________________

1. Information on critical illness

a) Describe the nature and severity of the condition affecting the insured child.______________________________

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Diagnosis or operation date: ________-________-________
Year Month Day

b) Date of onset of symptoms: ________-________-________
Year Month Day

Please describe the symptoms. ______________________________

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c) When did the insured child first see a doctor for this condition? ________-________-________
Year Month Day

Name of physician consulted: ______________________________

d) Did the insured child undergo tests or examinations to confirm the diagnosis?
If yes, please provide details and dates.

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e) Has the insured child suffered from or received treatment for an identical or similar condition?
If yes, please provide details and dates.

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2. Medical consultations

a) Please provide the name and address of the insured child's personal physician.

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(reverse)

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Medical consultations (continued)

b) Please indicate the other physicians or specialists consulted by the insured child for this illness.

Name	Address	Dates of Consultation (Year - Month - Day)
		- -
		- -
		- -

c) If the insured child was treated in a hospital or another establishment, please provide the following details:

Name of hospital	City	Admission date (Year - Month - Day)	Discharge date (Year - Month - Day)
		- -	- -
		- -	- -
		- -	- -

d) What other treatments or medications has the insured child received, or still receives, for this illness?

Name of treatment	Hospital /Institution/Attending physician	Dates (Year - Month - Day)
		- -
		- -
		- -

3. General information

a) Will you file a claim for this illness with another company? ☐ Yes ☐ No
If yes, please specify:

Name of insurer	Type of benefit	Amount of benefit	Request already submitted?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

b) Please provide all other information that you think would be helpful with your claim.

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I, the undersigned,/We, the undersigned, hereby declare that these answers are true and complete.

Name of insured child	Name of father, mother or legal guardian
Signature of insured child	Signature of father, mother or legal guardian (if the child is a minor)
Date (year/month/date)	(________)________ Father's, mother's or legal guardian's telephone number

Please provide a copy of the insured child's birth certificate