La Capitale

CLAIM FOR CRITICAL ILLNESS
Claimant's statement

- This form is to be completed by the insured or by someone else on his or her behalf, if he or she is unable to complete it alone.
- The Insurer reserves the right to require additional information if it deems necessary.
- The Insurer assumes no liability for any fees for providing proof relating to this claim.

Insured's Identification

Name ____________________ Sex: F ☐ M ☐

Address of the Insured ____________________ Postal Code

Date of Birth: ______-______-______ (Year Month Day)

Policy no: ____________________

Tel.: (____)____________________ Home

Occupation: ____________________

Tel.: (____)____________________ Work

1. Claim and Related Details

a) Please describe the nature and extent of your Critical Illness: ____________________

Date of the diagnosis or surgery: ______-______-______ (Year Month Day)

b) Date symptoms first commence: ______-______-______ (Year Month Day)

Please describe these symptoms: ____________________

c) On what date did you first consult a medical practitioner in connection with your illness: ______-______-______ (Year Month Day)

Name and address of the physician seen: ____________________

d) Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates:

____

e) Have you previously suffered from, or received treatment for, a similar or related condition? If yes, please give details including dates.

____

2. Medical Consultations

a) Please provide the name and address of your personal physician: ____________________

(continued on back)

Medical Consultations (Cont'd)

b) Please provide details of any other doctors or specialists who have been consulted in connection with your illness:

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

c) If you have been treated at a hospital or similar institution, please supply the following information:

Name of Hospital	City	Date of Admission (Year-Month-Day)	Date of Discharge (Year-Month-Day)
		- -	- -
		- -	- -
		- -	- -

d) What other treatment or medication have you received and are you currently receiving in connection with your condition?

Type of Treatment	Hospital/Physician	Dates (Year-Month-Day)
		- -
		- -
		- -

3. General

a) Has any blood relative suffered from a similar or related condition? If yes, please indicate:

Relationship	Nature of Illness	Date and Age at Which Illness was First Diagnosed (Year-Month-Day)	Age
		- -	
		- -	
		- -	

b) Are you insured for benefits related to this condition from another company? If yes, please indicate:

Name of Insurer	Type of Benefit	Amount of Benefit Insured	Has a Claim been Submitted?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

c) Do you use tobacco products? Yes ☐ No ☐

If yes, please indicate amount per day. ______________________

How long have you used tobacco? ______________________

If no, did you previously use tobacco products? Yes ☐ No ☐

On what date did you quit? ______________________

d) Please provide any further information which you think might be helpful in support of your claim.

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I certify that the above statements are accurate and complete.

______________________ Date

______________________ Signature of disabled person

Please submit a copy of your birth certificate if you have not already done so.