CLAIM FORM - CRITICAL ILLNESS

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

a) Name of Covered Person / Participant_____

b) Identity Card No CNIC #

c) Date of Birth | | | | | | | | | d) Age _____ e) Sex M ☐ F ☐

f) Occupation _____

g) Address _____

h) Telephone # _____ j) Bank Account No. Name & Branch _____

_____

2. Critical Illness Details

a) Name of Disease _____ b) Date of Diagnosis _____

b) Hospital Name _____ d) Name of Doctor _____

e) Date of Onset of Symptoms _____ f) Date of Onset of Disease_____ g) Age at Onset _____

h) Date(s) of Confinement at Home

Date From	Date To	Treatment Provided

k) Date(s) of Confinement at Hospital

Hospital Name	Date From	Date To	Treatment Provided

3. In Case of Surgery

a) Place of Surgery / Hospital Date & Time

Hospital Name	Dr. Name	Date From	Date To	Reason of Surgery

4. Declaration by the Policy Holder / Participant's

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
Date : _____

Place :_____

_____
Signature of Witness
Name : _____

Address _____

Please attach the original documents of the following.

- Copy of CNIC of Claimant
- Medical History / Record
- Doctor Advice
- Hospitalization Record
- Hospital Discharge Certificate / Summary
- Prescriptions

PART 2 – MEDICAL ATTENDANCE STATEMENT

1. Medical Attendant Detail
   a) Name of Doctor _____
   b) Name of Hospital / Address _____/_____
   c) PMDC NO. _____
   d) Specialty _____ e) Telephone No _____
   f) Is person Covered related to you ? If yes, please give details _____
   g) Date of First Visit & details of complaints _____
   _____
   h) Date of Last Visit _____ i) Diagnosis _____
   _____
   i) Cause of Disability _____

2. Other Information
   a) Past history of the disease _____
   b) Since how long deceased was suffering from the disease _____
   c) Please specify any other information which is pertinent _____
   d) Details of Complaints, Investigation & treatment during last 3 years _____
   _____
   e) In your opinion, is disability suffered considered to be total and permanent nature and 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 e) Name of Employer _____ b) Address of Employer _____/_____ c) Telephone No. _____ d) email _____ e) 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 Date _____ Place _____ _____ Signature of Witness Name : _____ Address _____

Complaints in Respect of Insurance Policy

If you have any complaint or grievance against the insurance company, broker, agent, surveyor or bank representative in respect of your insurance policy, you may file your complaint with the following offices:

1. **Federal Insurance Ombudsman**

   2nd Floor, Pakistan Red Crescent Society, Annexe Building, Plot# 197/5, Dr. Doud Pota Road, Karachi.
   Phone: 021-99207761-62
   Website: www.fio.gov.pk/

2. **Official Coordinator, Small Disputes Resolution Committee -Karachi**

   The Deputy Director, Specialized Companies Division
   5th Floor, State Life Building No. 2, Wallace Road,
   Off. I.I. Chundrigar Road, Karachi.
   Direct no.: 021-99002021
   UAN: 021-111-117-327
   Email: complaints@secp.gov.pk

3. **Official Coordinator, Small Disputes Resolution Committee -Lahore**

   The Deputy Registrar of Companies, Company Registration Office, Lahore.
   Associate House, 3rd & 4th Floor, 7-Egerton Road, Lahore.
   Direct no.: 042-99014050
   UAN: 042-111-117-327
   Email: complaints@secp.gov.pk

4. **Official Coordinator, Small Disputes Resolution Committee-Islamabad**

   The Management Executive, Insurance Division
   3rd Floor, NICL Building, Islamabad.
   Direct no.: 051-9195391
   UAN: 051-111-117-327
   Email: complaints@secp.gov.pk

5. **Securities and Exchange Commission of Pakistan**
   Toll-Free No.: Toll free 080088008

بیمہ پالیسی کے متعلق شکایات

اگر آپ کو اپنی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سروئیر یا بینک نمائندے کے خلاف کوئی شکایت ہو تو آپ درج ذیل دفاتر میں رابطہ کر سکتے ہیں:۔

دفتری رابطہ کار (اسلام آباد)
اسمال ڈسپیوٹس ریزولوشن کمپنی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
تھرڈ فلور، این آئی سی ایل بلڈنگ، اسلام آباد

براہ راست نمبر: 051-9195391
یو اے این: 051-111-117-327
ای میل: complaints@secp.gov.pk

وفاقی انشورنس محتسب۔
سیکنڈ فلور، پاکستان ریڈ کریسنٹ سوسائٹی، انیکسی بلڈنگ،
پلاٹ نمبر 197/5، ڈاکٹر داؤد پوتا روڈ، کراچی

فون: 021-99207761-62
www.fio.gov.pk

سیکیورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
ٹول فری نمبر: 080088008 ٹول فری

دفتری رابطہ کار (لاہور)
اسمال ڈسپیوٹس ریزولوشن کمپنی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
ایسوسی ایٹ ہاؤس، 3rd فلور، 07- ایجرٹن روڈ، لاہور

براہ راست نمبر: 042-99014050
یو اے این: 042-111-117-327
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (کراچی)
اسمال ڈسپیوٹس ریزولوشن کمپنی سیکیورٹیز اینڈ ایکسچینج کمشن آف پاکستان
5th فلور، اسٹیٹ لائف بلڈنگ 02، ولاس روڈ،
آف آئی آئی چندریگر روڈ، کراچی۔

براہ راست نمبر: 021-99002021 یو اے این: 021-111-117-327
ای میل: complaints@secp.gov.pk