Form 905/A2

CLAIM FORM FOR LIC's Cancer Cover policy

The form is to be filled by the claimant. The issue of this form is not to be taken as an admission of liability.

(CLAIM FORM AND OTHER DOCUMENTS TO BE SUBMITTED TO LIC BRANCH ONLY)

Branch Office…………….Policy No:…………………………….

Name of the Life Assured: ……………………………………………………Date of Birth: ……………………………..

Current Address in full and Mobile No

………

……..

Details about Habits of the Life Assured

Substance	**Form of consumption**	**Quantity**	**Duration**
Tobacco	Cigarettes/Bedi /Gutka/Chewing tobacco	___No of sticks or ___packets	___Years___Months
Alcohol	Wine/Whisky/Beer	Per Day____ml /___Bottles	___Years___Months
Any other			

Details of the Illness

1. When the symptoms were first noticed?:...
2. Date of first consultation:…………………………Date of Diagnosis:……………………………….
3. **Please give details of all consultations/ investigations e.g. Blood Reports, X-Ray, Sonography/mammography/CT Scan/MRI/Biopsy/FNAC/PAP Smear etc. (attach a separate list if additional space is needed)**

Date	**Name of the Hospital/Doctor**	**Address & Contact Details of Hospital/Doctor**	**Diagnosis**

4. **In case of Salariedindividuals,please give the details of the medical / sick leave taken in the last 5 years. Pleaseprovide copies of the Medical Certificates / records provided by the Life Assuredin support of the leave:**

Dates		**Reasons as per medical certificate / leave application**
From	**To**	

5. **Details of consultation or treatment received (E.g. Surgery/Chemotherapy/Radiation)**

Date	Name of the Hospital/Doctor	Address & Contact Details of Hospital/Doctor	Treatment received

6. **Do you have any other critical illness policies/mediclaim with LIC or any other company? If yes, please provide details'**

Policy No	Company's name	Date of commencement	Sum Assured	Servicing Branch

1. **Is there a past history of tumor/cancer/HIV Infection? If yes, please provide details of**

Date	Name of the Hospital/Doctor	Address & Contact Details of Hospital/Doctor	Treatment received

I ……………………………………………………………………………..do hereby declare that the statements made herein above are true and complete in each and every respect. **I authorize the medical attendant, hospital, physician who has/have treated or examined me for any ailment or illness to divulge any information regarding my health known to them either in the past or present to LIFE INSURANCE CORPORATION OF INDIA and its officers.**

Signature of witness Signature of the Life Assured

Name of the witness Date:

Address and mobile number: Place:

Note: Kindly submit original reports of all investigations, Histopathology reports/IHC Operating surgeon's report, Consultant's reports, all blood test reports, Hospital Discharge Summary, follow-up reports any other reports available with you.