

Claim form - PNB MetLife Mera Heart & Cancer Care

POLICY NUMBER																			
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Important instructions:

The submission of the filled-up claim form, along with the required mandatory documents, is not to be construed as an admission of liabilities of our Company under the policy. No agent/intermediary has been or is authorized to admit any liabilities on behalf of the Company.

Early submission of this form along with the required mandatory documents, as provided below, will enable us to process your claim faster. PNB MetLife shall not be responsible for any delay in the processing of the claim on account of submission of incomplete claim form and/or non-submission of the mandatory documents.

This form is to be filled in completely in BLOCK letters.

Please Counter-sign where amendments/alterations are made in the form.

Witness signature of a Gazetted Officer/Notary Public/Magistrate or Person of local standing is mandatory.

Forms & all requirements to be submitted at the nearest branch office of PNB MetLife or the address mentioned above.

Section A: DETAILS OF THE LIFE INSURED

Name: _____ Age: _____																			
Address (Current Residential Address): _____																			

City _____			Pin Code _____			State _____													
Contact Number: Landline _____					/Mobile _____														
E-mail Address: _____		PAN No. / Form 60: _____		*Aadhaar No: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> <td style="width: 15px; text-align: center;">X</td> </tr> </table>						X	X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X										
*Only last 4 digits to be mentioned.																			

Section B: MEDICAL HISTORY OF LIFE INSURED

Name of Illness/Disease/Injury Sustained: _____	
Symptoms: _____	
Duration of symptoms: _____ Date of Diagnosis: _____	
When were these symptoms first evident/occurred: _____	
Date and Time of Admission _____ Date and Time of Discharge _____	
Name of hospital: _____	
Have you ever had the similar condition in past: <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes," provide details) _____	

Nature of Illness and Habits	Date of diagnosis of Illness
<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> IHD <input type="checkbox"/> Malignancy Other.....	
<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs If yes, Duration of Consumption _____ & Quantity Consumed _____	

CRITICAL ILLNESS ACKNOWLEDGEMENT SLIP

Policy number(s) _____ Name of claimant _____ Branch name & code _____ Date: _____ Employee name & Code _____	Company Seal & Stamp with Date and time
Documents: <input type="checkbox"/> Original Policy Document <input type="checkbox"/> Photo identity & residence proof <input type="checkbox"/> Doctor's Certificate - Critical Illness Submitted: <input type="checkbox"/> Cancelled cheque / Copy of bank passbook <input type="checkbox"/> Doctor's Certificate - Critical Illness <input type="checkbox"/> Complete medical records for diagnosis and treatment of the illness diagnosed i.e. all test/investigation reports, discharge summary, indoor case paper	

This acknowledgement slip should not be construed as acceptance of the claim. The Company reserves its right to call additional documents, information and any further requirements necessary in order to decide on processing of the claim.

Information about the Critical Illness (Please tick the illness diagnosed)

List of Heart conditions covered under Heart Cover	List of Cancer conditions covered under Cancer Cover
Mild Stage	
<input type="checkbox"/> Angioplasty (stenting for Coronary Arteries) <input type="checkbox"/> Angioplasty and Stenting for Carotid Arteries <input type="checkbox"/> Endarterectomy <input type="checkbox"/> Renal Angioplasty <input type="checkbox"/> Percutaneous procedures for Repair or Replacement of Heart Valves <input type="checkbox"/> Pericardectomy <input type="checkbox"/> Minimally Invasive Surgery for Aortic Aneurysm <input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Specified Early Stage Cancer or Carcinoma-in-situ
Moderate Stage	
<input type="checkbox"/> Initial implantation of Permanent Pacemaker of Heart or Insertion of Implantable Cardioverter defibrillator (ICD) <input type="checkbox"/> Surgery to place ventricular assist devices or total artificial hearts	Following Cancer related Surgeries necessitated due to an eligible Carcinoma-in-situ cancer claim* are covered: <input type="checkbox"/> Mastectomy for Carcinoma-in-situ of the breast <input type="checkbox"/> Orchiectomy for Carcinoma-in-situ of the testis <input type="checkbox"/> Cystectomy for Carcinoma-in-situ of the Urinary Bladder/T1NoMo Urinary Bladder Cancer <input type="checkbox"/> Total Abdominal Hysterectomy and Bilateral Salpingo- Oophorectomy for Carcinoma-in-situ of the Cervix / Carcinoma-in-situ of the Uterus / Carcinoma-in-situ of the Ovary *A CIS cancer claim must be payable for payment of this benefit
Severe Stage	
<input type="checkbox"/> Myocardial infarction (First Heart Attack – Of Specified Severity) <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Major surgery of the Aorta <input type="checkbox"/> Open Chest CABG <input type="checkbox"/> Open Heart Replacement or Repair of Heart Valves <input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Major Cancer diagnosis

Section C: PAYMENT – NEFT

Bank Account no: _____
 Name of bank: _____
 IFSC code: _____

Section D: DECLARATION & AUTHORIZATION

I do hereby declare that all the above statements are true and complete and that nothing has been suppressed or with-held from my side. understand that in furnishing claim form PNB MetLife has not admitted liability or waived any of its rights under the policy. I hereby authorize the physician or hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information or furnish the records regarding my state of health which he/they may have acquired whether before or after the policy was issued by PNB MetLife. I/We hereby further consent, and authorize, PNB MetLife to use and disclose any of the personal and sensitive information of mine/our collected or available with PNB MetLife (whether contained in this statement or obtained otherwise) which may include KYC documents to any individual/organisation/entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry association/federations, for the purpose of processing this claim and/or for providing subsequent services.

Signature/Left Thumb impression _____ Date _____

Declaration by the person filling in the Critical Illness Claim form. (in case the Critical Illness Claim form is filled up / signed in a language different from that of application form)

I hereby declare that I have fully explained the contents of the Critical Illness Claim form to the claimant in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the claimant and the replies have been read out to, fully understood and confirmed the claimant.

The content of the form and document have been fully explained to me and that I have fully understood the content mentioned herein and its significance for the proposed Claim

_____ Date _____ Place _____ Signature of Declarant _____ Signature / Left thumb Impression Claimant/ Nominee _____

Name of Witness: _____ Signature of Witness: _____

Address of Witness: _____

Date: _____ Place: _____

Documents to be submitted along with this form:

- Original policy document
- Doctor's Certificate - Critical Illness
- Complete medical records for diagnosis and treatment of the illness diagnosed i.e. all test/investigation reports, discharge summary, indoor case papers
- All past medical records for any treatment taken
- Cancelled cheque
- Id & residence proof