pnb MetLife

Milkar life aage badhaein

PNB MetLife India Insurance Company Limited

Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

Group Critical Illness Claim Form

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

Section A: DETAILS OF THE INSURED MEMBER/EMPLOYEE

Group Policy No: ____________________ Member ID: ____________________

Designation/ Band/ Grade of deceased Member/ Employee: ____________________

Employee ID: ____________________

Full Name & Address of Insured Member/ Employee: ____________________

____

Name of Policyholder : ____________________

Date of Birth of Insured Member/Employee: ____________________ Date of Joining the Service ____________________

Last Drawn Salary: ____________(Monthly) ____________(Annual) ____________

Section B: MEDICAL HISTORY OF INSURED MEMBER/EMPLOYEE

Name of Illness/Disease/Injury Sustained: ____________________

Symptoms: ____________________

Duration of symptoms: ____________________ Date of Diagnosis: ____________________

When and where these symptoms first observed/diagnosed/occurred: ____________________

Date and Time of Admission ____________________ Date and Time of Discharge ____________________

Name of hospital: ____________________

Have you ever had the similar condition in past: ☐ Yes ☐ No *(If "yes," provide details)* ____________________

____

Nature of Illness and Habits	Date of diagnosis of Illness
☐ Hypertension ☐ Diabetes ☐ Asthma ☐ IHD ☐ Malignancy Other……………………………………	
☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs If yes, Duration of Consumption____________________ & Quantity Consumed____________________	

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

- ☐ Cancer
- ☐ First Heart Attack
- ☐ Open Chest CABG
- ☐ Blindness
- ☐ Parkinson's Disease
- ☐ Benign Brain Tumour
- ☐ Major Burns
- ☐ Coma
- ☐ Aorta Surgery
- ☐ Open Heart Replacement or Repair of Heart Valves
- ☐ Stroke resulting in permanent symptoms
- ☐ Kidney Failure requiring regular Dialysis
- ☐ Permanent Paralysis of Limbs
- ☐ Major Organ/ Bone Marrow Transplant
- ☐ Multiple Sclerosis with persisting symptoms

Section C: Details of Nominee/s

S.No	Nominee Name	Relationship	Benefit Share %	Address of Nominee

Section D: PAYMENT – National Electronic Fund Transfer ('NEFT') details of Member Insured / Nominee/s

Particulars	Insured Member	Nominee 1	Nominee 2	Nominee 3	Nominee 4
Name					
Bank Account no.					
IFSC Code					
Bank and Branch Address					

Section E: DECLARATION & AUTHORIZATION BY INSURED MEMBER/NOMINEE/S

I/We, the above named claimant/s, do solemnly declare that the foregoing statements are true and agree that furnishing this form, or any other form supplemental thereto, to the Company, shall not constitute an admission by it that there was any insurance in force on the critical illness in question or a waiver of any rights or defense. Notwithstanding, any law, custom or usage, prohibiting the furnishing of secret information obtained during the medical treatment/investigation of the member insured, I/We hereby authorize any doctor or other person, or any hospital, sanatorium, medical professional, hospital or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company, employer, benefit plan administrator, accountant or financial advisor or other institution to provide to PNB MetLife India Insurance Company Ltd, any of it offices, or Court of Law, or any investigative agency or independent administrator acting on its behalf, information concerning employment, finances or insurance, advice, care or treatment provided to Insured Member, or any information that may be required concerning the health of the Insured Member including information relating to mental illness, use of drugs, use of alcohol, HIV(AIDS) and / or sexually transmitted diseases. A Photostat copy of this authorisation shall be considered as effective and valid as the original.

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/application or obtained otherwise) which may include KYC documents to any individual/organization/ entity associated or affiliated with or engaged by PNB MetLife, including reinsurers, claim investigative agencies, vendors and industry associations/federations, for the purpose of processing this claim, application and/or for providing subsequent services, which will includes service arising out of claim settlement.

Signature of the Member Insured ________________________ Date ____________

Name ____

Name and Signature of Witness ________________________ Date ____________

Address of Witness ____

Signature of Nominee

Particular	Nominee 1	Nominee 2	Nominee 3	Nominee 4
Name				
Signature				
Contact No				
Date				

Declaration by Group Policy Holder

We confirm that the foregoing information including the details of the insured member stated above are true to the best of our knowledge and belief and are born out from our official records. We further confirm that, the Nominee/s if any mentioned in this form is/are as nominated by the employee for the purpose of vesting of his/her life Insurance benefits.

Signature of authorized signatory with Company Seal ________________________________ Date ____________

Name and Designation:____

Contact no.:____

Documents to be submitted along with this form:

- Attending physician certificate by a Specialist excluding the policy holder or the Insured member or the spouse or lineal relative of the Policy Holder / Insured member/Nominee/s
- 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 or NEFT details provided above
- Id & residence proof of the Member Insured / Nominee/s
- If the claim is submitted by the nominee/s, copy of the death certificate of the Insured member to be provided

There are few types of illness which are excluded for respective Critical Illness:

Cancer

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocytic leukemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection

Heart Attack

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
- Other acute Coronary Syndromes
- Any type of angina pectoris

Open Chest CABG

- Angioplasty and/or any other intra-arterial procedures
- any key-hole or laser surgery

Open Heart Replacement or repair of heart valves

- Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded

Coma

- Coma resulting directly from alcohol or drug abuse is excluded

Stroke resulting in permanent symptoms

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions

Major Organ/ Bone Marrow Transplant

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

Aorta Surgery

- Traumatic injury of the aorta is excluded

Multiple Sclerosis with persisting symptoms

- Causes of neurological damage such as SLE and HIV are excluded

Blindness

- Blindness should not be correctable by medical or surgical procedure

Parkinson’s disease

- Drug-induced or toxic causes of Parkinsonism are excluded

Benign Brain Tumor

- Cysts
- Granulomas
- Vascular Malformations
- Haematomas and
- Tumours of the pituitary gland or spinal cord