Shanta Life Insurance PLC
Shanta Western Tower, Level 10
186, Bir Uttam Mir Shawkat Sarak
Tejgaon I/A, Dhaka 1208, Bangladesh
info@shantalife.com

Critical Illness Claim Form

This form must be filled out by the policyholder

Insurance Types : ☐ Individual ☐ Group ☐ Others : _____

Policy No. / Member ID : _____ Policy Start Date : _____

Organizations Name : (**if Group/Bancassurance**) _____

Name of Insured/Claimant : _____

Date of Birth : _____ Mobile Number : _____

Address : _____

Bank Account Name : _____ Bank Name : _____

Branch Name : _____ Account Number : _____

Routing Number : _____

(Please attach a copy of cheque leaf)

Illness Background

Date of First Consultation : _____ Date of Diagnosis of the Disease : _____

Have you ever had the same or similar condition in past? (give ✓) ☐ Yes ☐ No

If Yes, mention details _____

I, the undersigned, hereby grant my full authorization to all physicians, hospitals, clinics, pharmacies, laboratories, employers, institutions, and any other relevant parties, to release to Shanta Life Insurance PLC all information pertaining to my medical history, consultations, prescriptions, treatments, and copies of any hospital or medical records related to my care. Furthermore, I acknowledge that any copy of this authorization shall be considered as valid and binding as the original.

_____ _____

Signature of Insured/Claimant Date

_____ _____

Signature of Authorized Person (Group/Bancassurance) Date & Seal

Please submit all treatment documents such as prescription, investigations reports- blood, Urine, X-ray, ECG, Ultrasonogram etc., discharge certificate of insured illness.

To be completed by respective specialized physician and/or any physician who was involved in the treatment process (MO, RP, RS etc.)

Name of Patient : _____ Date of Birth : _____ Age : _____ (years)

01. When did you first visit the patient after first onset of symptom of the illness? (রোগের লক্ষণ শুরু হওয়ার কতক্ষণ পর আপনি প্রথম রুগীকে দেখেছেন?)
Please explain details about the treatments provided by you

_____

02. Does the patient had similar symptom in the past? (give ✓) ☐ Yes ☐ No

If "Yes" please describe in details: (a) Date of illness _____ (b) Duration of illness _____

(c) Treatment received _____

03. Is the patient suffering from any other disease? (give ✓) ☐ Yes ☐ No

If Yes, mention details _____

04. Your diagnosis _____

05. Name of Investigations (Already Done) : _____

06. Date of Last Examination : _____

07. Prognosis : _____

_____ _____

Name of Physician Mobile Number

_____ _____

BMDC Reg. No Address

_____ _____

Signature of Physician and Date Official Seal