Cancer Cover Claim Form

Section A

Full name of claimant: _____

Address: _____

_____

Home telephone number:____ _____ Mobile number: _____

Policy number: _____ Date of birth: _____

Occupation: _____

Name and address of every doctor/specialist consulted for this condition

_____

_____

Please confirm diagnosis: _____

Please confirm date of diagnosis: _____

Were you admitted to hospital: Yes _____ No _____

Which hospital: _____

As an in-patient _____ or Out-patient _____

Date admitted _____ Date discharged _____

Please confirm if you have any other insurance cover for this illness: Yes _____No _____

Are you a smoker? Yes _____ No _____

If yes, please provide full details:

_____

_____

By providing your Personal Information to AIG or Personal Information regarding other individuals you represent that you have the authority to do so and consent to the collection and processing (including the disclosure and international transfer) of this Personal Information as stated in the Privacy Policy which is available at www.aig.ie, by e-mailing postmaster.ie@aig.com or by writing to the Data Protection Officer at AIG Europe Limited, Ireland Branch, AIG House, Merrion Road, Dublin 4.

I hereby declare the foregoing particulars to be true in every respect

Signature: _____ Date: _____

Medical Authorisation:
On production of this authorisation, or a photocopy thereof, I authorise you to furnish AIG with full reports on the condition of _____ including the history of the complaint(s).

Signature of claimant: _____ Date: _____

Medical Certificate

Section B

To be completed by the attending doctor and supplied at the expense of the policy holder

Name of claimant: _____

Date of birth: _____

Are you the claimant's usual medical attendant? Yes _____ No _____

Please confirm diagnosis: _____

Please confirm date of diagnosis: _____

Is diagnosis is cancer please confirm the primary site: _____

_____

Has the claimant previously been diagnosed as suffering from this condition:

Yes _____ No _____

If yes, please confirm when this condition was first diagnosed, and when, if appropriate, the claimant was declared as being medically free of this condition:

_____

_____

Has surgery been performed for this condition: Yes _____ No _____

Please confirm surgical procedure performed: _____

Please confirm the date the claimant was confined to hospital for treatment of this condition:

Admitted: _____ Discharged: _____

Please provide brief details of proposed future treatment:

_____

_____

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I certify that these particulars are true and correct:

Signature: _____ Qualifications: _____

Address: _____

Stamp: