CRITICAL ILLNESS CLAIM FORM

FOR INDIVIDUAL LIFE POLICIES:

Details of the Policyholder:

Policyholder's name: _____Policy No: _____

Policyholder's ID No.:_____ Tel. No.:_____

Postal Address_____ Postal Code _____Town _____

Details on the Diagnosis:

What is the specific critical illness for which the claim is being made? _____

When did the symptoms of this illness first appear? _____

On which date did you first consult a medical practitioner in connection with the illness? _____

When was the first diagnosis of the critical illness? _____

Describe any other diseases or illness affecting present condition? _____

Have you ever had the same or similar condition? _____ (If "yes," state when and describe.)

_____

Please provide the name and address of your personal physician _____

_____

List the name, address and telephone number for all attending physicians for the critical illness (please attach a separate list if additional space is needed)

1. _____
2. _____
3. _____
4. _____

If the critical illness required hospitalization, provide the name and address of the treating facility (please attach a separate list if additional space is needed)

1. _____
2. _____
3. _____
4. _____

Declaration:

I hereby declare and certify that all particulars furnished herein are the true records at the date of coverage and at date of claim.

Name of the claimant: _____

Email: _____ Mobile No: _____

Postal Address: _____ Postal Code: _____Town: _____

Signature: _____ Date: _____

Kindly tick against your most preferred mode of communication from us.

1. Email ☐ 2. Postal Address ☐ 3. CIC Branch ☐ (Indicate Branch) _____

Critical Illness Claim Requirements:

(All copies MUST be certified by a CIC Branch Administrator).

1 Copy of ATM card of policy holder.

2 Copy of policy holder's ID

3 A Doctors Report on the illness.

4 Copy of recent pay slip of policy holder (Check off).

PS: We may seek further documentation in the event the above documents are not sufficient to analyze the claim.