

Critical Illness / Terminal Illness Claim Intimation Form

(To be accompanied by all hospital records related to the Illness)

Policy No: _/ _/ _/ _/ _/ _/ _/ _/ _/

Name of Life Assured: _____

Type of Critical/Terminal Illness: _____

Date of Illness: _____ Place of Illness: _____

Detailed Description (giving cause):

The above statements are true and correct to the best of my knowledge.

Signature of Claimant: _____ **Dated:** _____

Name of Claimant: _____ **Relation to the Life Assured:** _____

Address: _____

Phone Number: _____ **Email id (if any):** _____

If the executant is an illiterate (affixing thumb impression) or a person subscribing his/her signature in vernacular then the witness has to attest the thumb impression / Signature and execute the following declaration

Certified that the contents of this Form were explained by me to Mr./Mrs./Ms. _____
(Insert name) in _____ language and that he/she has affixed his/her signature/thumb impression thereto in my presence after thoroughly understanding the same. I have truthfully recorded the replies.

Date: _____

Signature of witness: _____

Name: _____

Address: _____

Phone Number: _____

