



CRITICAL ILLNESS / DISABILITY CLAIM INTIMATION FORM

Name of the Life Assured: _____

Policy Numbers : _____

Name, Address and telephone number of claimant: _____

Relation to Life Assured: _____

Name of illness (For Critical Illness): _____

Cause and nature of disability: _____

Date of occurrence of event: _____

Details of doctors/ hospitals where diagnosis and treatment was carried out:

| Name of hospital/doctor | Address and tel no of doctor | Dates of consultation /admission and discharge |
|-------------------------|------------------------------|------------------------------------------------|
| | | |
| | | |
| | | |

(Signature / thumb impression of the claimant)

(Date)

In case of thumb impression of the claimant, please provide the name, signature, address & phone number of the person filling the form

(Name)

(Signature)

Address & Phone number: _____