CRITICAL ILLNESS CLAIM FORM

1) **Full Name and Address** _____

_____

2) **Policy Number** _____

3) **Telephone Number** _____

4) **Have you undergone any tests or investigations to confirm this diagnosis? If so, please give details** _____

5) **What treatment are you currently receiving** _____

6) **On what date did symptoms first commence** _____

7) **Have you suffered from the same or any similar condition previously? If so, please give details including dates.** _____

8) **Name of address of the medical attendant treating This condition.** _____

9) **When did you first consult him or any other doctor for this condition.** _____

10) **Please provide full details of any other insurance policies under which you may receive payment for this condition.** _____

(P.T.O.)

DECLARATION

I Declare that the above statements are accurate and complete and I hereby authorize any doctor whom I have consulted to furnish with any information concerning my past physical or mental health and present condition, I also hereby authorise the release to of any other information which considers relevant to enable my claim to be dealt with.

I understand that by furnishing this form and investigating the claim or by accepting proof of claim shall not be held to admit the validity of any claim nor to have waived any of its rights in defence of any claim arising under the policy.

Signed _____ Dated _____

(P.T.O.)