Paralysis Insurance Claim Form

Personal Information

Full Name

Date of Birth

Policy Number

Contact Number

Address

Incident & Diagnosis Details

Date of Incident

Date of Diagnosis

Type of Paralysis

Description of Paralysis

Cause of Paralysis

Hospital/Clinic Name

Attending Doctor

Doctor's Contact

Claim Details

Amount Claimed

Supporting Documents

Choose File No file selected

Additional Information

Declaration

I declare that the information provided is true and correct to the best of my knowledge.

Signature

Date