Terminal Illness Insurance Claim Form

1. Policyholder Information

Full Name

Date of Birth

Policy Number

Contact Number

Address

2. Illness Details

Diagnosis

Date Diagnosed

Expected Life Expectancy

Attending Physician's Name

Hospital/Clinic Name

3. Payment Details

Preferred Payment Method

Bank Account Details

4. Supporting Documents

Attach Medical Reports/Certificates

Choose File No file selected

5. Declaration & Consent

I hereby declare that the information provided is true and complete. I give consent for the insurer to contact my physician and request further information as needed.

Signature

Name

Date