Critical Illness Insurance Claim Form

Policyholder Information

Full Name

Policy Number

Date of Birth

Contact Number

Email Address

Address

Illness Details

Critical Illness Diagnosed

Date of Diagnosis

Treating Physician / Hospital

Physician / Hospital Contact

Description of Illness / Diagnosis

Bank Details for Claim Payment

Account Holder's Name

Bank Name

Account Number

Bank IFSC/Swift Code

Declaration

Signature

Date