Critical Illness Disability Claim Statement

Personal Information

Full Name

Date of Birth

Policy Number

Contact Number

Address

Diagnosis Details

Nature of Critical Illness

Date of Diagnosis

Attending Physician/Clinic

Description/Comments

Work Status

Current Occupation

Are you currently working?

Date Last Worked

Describe how your illness prevents you from working

Treatment Information

Type of Treatment/Medication

Next Appointment Date

Declaration

Signature

Date