Critical Illness Disability Insurance Claim Statement

Personal Information

Full Name

Date of Birth

Policy Number

Contact Number

Address

Diagnosis Details

Diagnosis

Date of Diagnosis

Hospital/Clinic Name

Attending Physician

Description of Symptoms

Employment Details

Employer Name

Occupation

Current Work Status

Last Date Worked

Declaration

I declare that the information given is true and complete to the best of my knowledge.

Signature

Date