

Insurance Claim Form for Terminal Illness Benefit

1. Policyholder Details

Full Name

Date of Birth

Policy Number

Contact Number

Address

2. Diagnosis Details

Date of Diagnosis

Name of Illness/Disease

Details of Diagnosis

Treating Doctor's Name

Doctor's Contact Number

Medical Institution/Hospital

3. Claimant Statement

Relationship to Policyholder (if not self)

Reason for Claim

4. Bank Account Details for Payment

Account Holder Name

Bank Name

Account Number

IFSC / Swift Code

Bank Branch Address

5. Declaration & Signature

I hereby declare that the information provided above is true and complete to the best of my knowledge. I authorize the insurer to obtain further medical or other information as required.

Signature

Date