

Critical Illness Policy Surrender Form

Policy Details

Policy Number

Policyholder Name

Date of Birth

Contact Number

Email Address

Reason for Surrender

Bank Account Details for Refund (if applicable)

Account Holder Name

Bank Name

Branch

Account Number

IFSC Code

Declaration

I hereby request to surrender my Critical Illness Policy as stated above. I declare that the information provided is true

and correct to the best of my knowledge.

Signature of Policyholder

Date

Witness Name

Signature of Witness

Date