Critical Illness Rider Claim Form

Instructions: Please fill out all relevant fields and attach required supporting documents. Incomplete forms may delay your claim processing.

Policyholder Information	
Policyholder Name:	
Policy Number:	
Contact Number:	
Email Address:	
Mailing Address:	
Claim Details	
Date of Diagnosis:	
Name of Illness (Covered Condition):	
Treating Physician's Name:	
Hospital/Clinic Name:	
Description of Diagnosis and Treatment:	
Are you currently employed?	○ Yes ○ No

Supporting Documents Checklist

- ☐ Certified copy of diagnosis report
- ☐ Medical records and investigation results
- ☐ Valid ID proof
- ☐ Other relevant documents (please specify)

Declaration & Signature

I hereby declare that the information provided is true and complete to the best of my knowledge. I authorize the insurance company to obtain any further information required regarding this claim.

Policyholder's Signature: _____ Date: _____

Note: Submission of this form does not guarantee approval of the claim. The insurance company reserves the right to request additional documentation if deemed necessary.