Critical Illness Benefit Claim Form Sample

The **critical illness benefit claim form sample** provides a clear template for submitting claims related to covered serious health conditions. It ensures all necessary information is accurately documented to facilitate timely processing by insurance providers. Using this sample helps policyholders understand the required details for a successful claim.

Policyholder Details

Policy Number:

Full Name:

Date of Birth:

Gender:

Select

Contact Number:

Address:

Critical Illness Details

Type of Critical Illness:

Date of Diagnosis:

Attending Doctor's Name:

Hospital/Clinic Name:

Doctor/Hospital Contact Number:

Attachments

Please attach the following documents:

- Valid ID of Policyholder
- Medical Diagnosis Report
- Hospital/Doctor's Certificate
- Policy Document Copy
- Any other supporting documents

Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge. I authorize the insurance provider to use the information for claim assessment and processing.

☐ I agree to the terms of declaration.

Submit Claim Form