



Sar Utha Ke Jiyo

CRITICAL ILLNESS / DISABILITY CLAIM INTIMATION FORM

Name of the Life Assured: _____

Policy Number/s: _____

Name, address and telephone number of the Claimant: _____

Relation to Life Assured: _____

Name of illness (for Critical Illness): _____

Cause and nature of disability: _____

Date of occurrence of event: _____

Details of doctors / hospital where diagnosis and treatment was carried out:

Name of the hospital / doctor	Address and tel. no of the doctor	Dates of consultation / admission and discharge

(Signature/thumb impression of Claimant)

(Date)

In case of thumb impression of the claimant, please provide the name, signature, address & phone number of the person filling the form.

(Name)

(Signature)

Address & phone number: _____