



Aviva Life Insurance Company Limited

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CRITICAL ILLNESS CLAIM - CLAIMANT'S STATEMENT

POLICY NO : _____

CLAIMS PROCEDURE

- 1) Life Assured will be responsible for the accuracy and integrity of the information provided. Failure to provide details or disclose all relevant information may delay the claim assessment.
- 2) The medical reports fees (if any) will be borne by the Life Assured.
- 3) Please continue to pay your premium until we have informed you the outcome of your claim. We advise that Aviva Life Insurance Company Limited does not admit liability by the mere issue of this or any other form.

1. Name of Life Assured:	I.C/Passport/B.C. No:	Date of Birth:	
Occupation:	Marital Status:	Gender:	
Name of Employer:		Date of Employment:	
2. Name of Assured (if different from Life Assured):	I.C/Passport No:	Date of Birth:	Gender:

3. Nature of Claim and Related Details.

i) Describe fully the extent and nature of Life Assured's illness and/or injuries.

ii) Date Life Assured FIRST noticed the symptoms: (dd/mm/yyyy) _____

iii) Date Life Assured first consulted a medical practitioner for his/her illness. (dd/mm/yyyy) _____

iv) Has Life Assured previously suffered from, or received treatment for a similar or related illness? **Yes / No.**
If "Yes", please furnish full details.

v) Date Life Assured was told of the diagnosis. (dd/mm/yyyy) _____

4. (i) Give the details of doctor whom Life Assured has consulted in connection with Life Assured's illness.

<u>Name of Doctor</u>	<u>Name & Address of Clinic/Hospital</u>	<u>Date of First / Last Consultation</u>
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(ii) If Life Assured was treated at a hospital or similar institution, please supply the following information.
Name of Hospital or Institution Date of Admission Date of Discharge Reasons of Admission

(iii) Please provide the name and address of Life Assured's **regular** doctor(s).

Name of Doctor Name & Address of Clinic/Hospital Date of First / Last Consultation

5. Is Life Assured insured for similar benefits with any other company? **Yes / No**.
 If "Yes", please furnish the following information.

Name of Insurer Type of Policy Policy Effective Date Sum Assured

Authorisation

I, (IC/PP No.) declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

I further consent to Aviva Life Insurance Company Limited seeking information from any clinic, hospital, physician, person, organization, employer that may be required in connection with this claim and I authorize the giving of such information to Aviva. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Assured : Signature of Witness :

Name of Assured : Name of Witness :

Address : Address :

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Contact No : Contact No :

Date : Date :