# GROUP LIFE INSURANCE

## CRITICAL ILLNESS & ACCIDENT CLAIM PROCEDURE

All fields are mandatory. Please complete this form using black or blue ink. Write in BLOCK LETTERS and tick the relevant items. If the form is incomplete it might cause a delay. Kindly ensure that you submit a fully filled form together with the signed annexes, if applicable. Please retain a copy of this claim form and other correspondences with us for your future reference.

**For best results, use Adobe Acrobat or a similar PDF processing application to fill out the form.**

### 1. Policy and Employee Details

| | |
|---|---|
| 1. Policy Number | O I G |
| 2. Company Name | |
| 3. Sub-Company Name (if applicable) | |
| 4. Sum insured | |
| 5. Currency | |

### 2. Employee Details

| | | | |
|---|---|---|---|
| 1. Employee Name | | | |
| 2. Date of Birth | | Gender | ☐ *Male* ☑ *Female* |
| 3. Employement Status | ☑ *Temporary* ☐ *Permenant* | Employee Number | |
| 4. Work Location | | Date of Joining | |
| 5. Designation | | | |
| 6. Salary with breakup (Basic + Allowance) | | | |
| 7. Date of Event | | | |
| 8. Cause of Critical illness | ☑ *Accident* ☐ *Sickness* | | |
| 9. Critical illness you are claiming for | | | |
| 10. Date of first diagnosis | | | |
| 11. Treatment Details | | | |

12. For Critical illness due to sickness, please specify when was the condition first diagnosed

## 3. General Details

1. Describe First symptoms of critical illness and date symptoms first appear

2. When did you first consult a doctor regarding these symptoms?

3. Please provide details of treatment, investigations, medications, or advice received

4. Have you previously suffered from the critical illness you are claiming for, or had any related illness ☑ *Yes* ☐ *No*
   If yes – Please provide the details including dates and symptoms.

5. Were you hospitalized? ☑ *Yes* ☐ *No*
   If yes – Please specify the dates

6. Were you disabled because of the accident or illness? ☐ *Yes* ☑ *No*
   If yes – Please specify the dates

7. Have you resumed work? ☑ *Yes* ☐ *No*
   If yes – Please specify the dates
   If no – when will you resume work?

## 3. General Details (continued)

5. Please tell us the name and address of your general physician.

| Physician Name | Address | Date of first visit | Telephone number | Email address |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 4. Accident Details (to be filled in case of accident only)

| | |
|---|---|
| 1. Date of Accident | |
| 2. Place and time | |
| 3. Event Details | |

4. Please give details of the injuries you had. Specify left/right for eyes, legs, foot

### 5. Witnesses

| Name | Address |
|---|---|
| | |
| | |

| | |
|---|---|
| 6. Name and Address of Police Station where accident was reported | |

## 5. Bank Details

| | |
|---|---|
| 1. Account Name | |
| 2. Account Number | |
| 3. Bank Name | |
| 4. IBAN (23 digits) | |

## 6. Sukoon's data Privacy Notice and Data Subject's Contest

Sukoon insurance PJSC (hereinafter referred to as "Sukoon") respects your privacy and is committed to protecting it. Sukoon abides by Federal UAE Data Protection regulations as is applicable to Sukoon within UAE. Each of the applicant(s), proposer(s), insured member(s), beneficiary(s), insurance intermediary(s), any person contacting Sukoon for any purpose (altogether reffered to as "Data Subject"/ "you"/ "your") hereby consents and authorises Sukoon insurance PJSC ("Sukoon") to collect, use, store, maintain, transfer, disclose, Process, Data Subject's personal data (which includes but is not limited to personal identification data, personal sensitive data, personal health data, as provided to and/or obtained by Sukoon) in accordance with Sukoon's data privacy policy as published on https://www.sukoon.com/privacy-policy ("Privacy Policy"), which each Data subjects confirms to have been notified and having read, consented to the same. The Data Subject confirms to have notified all other relevant Data Subject(s) about Sukoon Privacy Policy and to have obtained their relevant consents prio to transferring any of their personal data to Sukoon.

## 7. Authorization

I confirm that all particulars filled are true, accurate and complete. I confirm that all submitted/uploaded documents are true copy(ies) of the original documents. I also confirm my understanding that I am required to retain the original documents for a period of one year, within which Sukoon may request original documents anytime for verification purposes. In the event I do not provide the original or am unable to provide the authenticity of the submitted documents then Sukoon reserves the right to recover paid claim amounts if any. I understand that (i) any person, who intentionally conceals, makes false or misleading statement to obtain claim reimbursement, is subject to penalization and legal action, and may lead to the policy/claim being considered null and void, (ii) acceptance of claim form does not constitute acceptance of liability by the Insurer.

I hereby authorize Sukoon Insurance PJSC (hereinafter referred to as "Sukoon") to wire transfer claim payouts (if any) related to this claim form to the above bank details as updated by me. I understand that Sukoon reserves its right to use any alternate payout option if required. If ever Sukoon credits more amount than the correct benefit amount due to duplicate or erroneous funds transfer, I authorize Sukoon to revise the transaction and withdraw the overpayment. I will not hold Sukoon responsible or liable in any case of non-credit to the above bank account or if the transaction is delayed or not effected at all for reasons of incomplete/incorrect details filed in by me.

I hereby authorise Sukoon Insurance PJSC ("Sukoon") to collect, use, store, maintain, transfer, disclose, process, my personal data (which includes but is not limited to personal identification data, personal sensitive data, personal heath data in accordance with Sukoon's data Privacy Policy as published on https://www.sukoon.com/privacy-policy ("Privacy Policy"), which I confirm to have been duly notified and having read, consented to the same. In specific, I also confirm and authorize (i) Sukoon to collect, store, process, disclose and/or transfer my personal sensitive information (including my personal identifiable information, personal health information) to third parties including but not limited to my appointed broker, insurance intermediary, reinsurers, service providers, claim administrators, medical providers, emergency support/ assistance providers, IT service providers, professional advisors, consultants, auditors, administrative and/or support service providers, and other entities or persons , whether within or outside the UAE, as may be required in relation to underwriting, issuing, administering, processing, reinsuring, administering my insurance policy and/or any of my insurance claim(s) or as may be required by Sukoon in accordance with Sukoon' Privacy Policy (ii) Sukoon and its associate partners to contact me anytime (including electronically through email, SMS, and/or telephone) for seeking any additional information and/or for providing any additional information whether related to my insurance policy, my insurance claim and/ or Sukoon's other products or promotions. This authorization specifically overrides and supersedes over my DNRC (do not call registry) listing (iii) Sukoon to disclose and/or report my personal sensitive information (including my personal\identifiable information, personal health information) as required by law or regulatory requirements including in case of any complaint, legal proceedings, pursuant to an order of court of competent jurisdiction whether inside or outside UAE in such circumstances and/or if and as required by law or regulatory requirements. This authorization shall remain valid notwithstanding death or incapacity. I agree that a copy of this authorisation shall be considered as effective and valid as original.

**Name**

| | |
|---|---|
| | |

| **Signature** | **Date (mm/dd/yyyy)** |
|---|---|
| | |

# GROUP LIFE INSURANCE

## ATTENDING PHYSICIAN STATEMENT (B) – FOR CRITICAL ILLNESS PART I

### 1. General Details

**PART A**

1. Name of the Patient
2. Date of Birth
3. Is the Patient related to you? Yes ☑ No ☐
   If "Yes", How ?
4. Are you the family doctor for the Patient ? Yes ☐ No ☑
   If "Yes", when do the records for your patient start? When was the date your Deceased first attended you and for what reason?

**PART B**

1. Claim Event (to be filled in by insurer)
2. When did the patient first contact any doctor with any symptoms directly or indirectly relating to any disease which contributed to this claim?
3. What is the name and address of the other doctor(s)?
4. When did the patient first have these symptoms?
5. What were these symptoms?
6. Who referred the Patient to you? Yes ☐ No ☐
   If yes, please give full details of the name and address of that doctor.
7. What was the reason for the referral?

## 1. General Details (continued)

8. When did they first see the patient;
   What treatment and investigations did they carry out?

9. When was the date on which you first examined / treated the Patient in respect of the claimed event?

10. Please give details of that examination, including symptoms, investigations and treatment.

11. Please provide full and exact details of the diagnosis you made.

12. Did any other disease(s) contribute to the claim cause? Yes ☑ No ☐
    If yes, please give full dates and details

13. Has the patient previously suffered from the claim cause or any related illness or disorder? Yes ☐ No ☑
    If yes, please give full dates and details.

14. Is there a related family history in the immediate family? Yes ☑ No ☐
    If yes, please provide details.

15. Please describe the patient's habits, such as drinking and smoking ? Yes ☐ No ☑
    If yes, please provide the quantity and duration

16. If the claim resulted from an accident - can you advise whether drug or alcohol use was a factor in this and if there is any history of drug or alcohol abuse?

17. Name of hospital where the Patient was admitted

18. Address of hospital where the Patient was admitted

19. Date of admission and discharge

## 1. General Details (continued)

20. What was the final diagnosis?

21. Date of final diagnosis

22. What were the various tests done for confirming the diagnosis

23. Treatment given

24. Date of surgery

25. Any other past medical history? Yes ☐ No ☐
If yes, please provide full details including dates, duration, investigations and treatment

**We would be grateful if you could forward copies of any relevant hospital reports that are available. The provision of these will enable us to make an early decision on your patient's claim.**

## 2. Declaration

The above statements are true and complete to the best of my knowledge and belief and as per the records maintained by hospital/ clinic.

Name of the Physician

Qualification of the Physician

Registration Number

Contact number

Address of Hospital / Clinic

Stamp of the Clinic / Hospital / Doctor

**Name**

**Date**

**Signature with Doctor Seal, Stamp & License Number**