Arabia Falcon Insurance
التأمين العربية فالكون

Group Life – Death/Disability

Claim Form

If you are signing for someone else, include a copy of the durable power of attorney or executorship if not previously provided.

General Information

1. Policy No. / Certificate No.: ______________________________
2. Name of the company: ______________________________
3. Address: ______________________________
4. Date of Death/Disability: ______________________________
5. Name of Life Assured: ______________________________
6. Serial / Employee No. / Staff No.: ______________________________
7. ID No.: ______________________________
8. Details
    - Age ______________________________
    - Gender ______________________________
9. State the occupation of the Life Assured: ______________________________
10. Was he on official duty? ______________________________
11. Date of appointment in service? ______________________________
12. Date of death/Disability: ______________________________
13. Place of death/Disability: ______________________________
14. Cause of death/Disability: ______________________________
15. Name of hospital : ❑In ❑Out
16. (In or outpatient) ______________________________

Declaration

This form is to be filled in and signed by a family member.
I declare that the above statements are true.
I also hereby allow the insurer to get medical reports and other details from any hospital where the Life assured was treaded in the past.

Signature(s)

In order for us to process this request, please sign below and return.

Sign Here	Signature	Date *(DD/MM/YYYY)*

How to submit this form

Note: Attach the following to this Claim Form

- Original death/disability certificate
- Hospital report showing cause of Death/Disability
- Police reports in case of accident / unnatural events
- Copy of Labour card (Valid)
- Copy of passport / visa page
- Claim details in case of accident in foreign country

To finalize the payment process, we require the submission of the original forms

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