TPD / PPD

Claim Form

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

This claim form should be completed by the person who will receive benefits under the plan.
If the insured is unable to complete the details himself/herself this for may be completed by a family member, career or other person able to deal with the insured's affairs.
Please complete this form with the details of your claim. Prompt response and accurate information will help us to assess your claim more efficiently. Please complete all section of the form as requested.

Section A – Personal Details

Name of Claimant: _____
Date of Birth: _____
Address: _____
Phone No.: _____
Occupation:
Policy No.:

Section B – Nature of claim and related benefits

1. What is the condition or disability you are currently suffering from? _____
2. When did symptoms first occur? _____
3. On what date did you first consult a medical practitioner in connection with you illness and whom did you consult? Give details of the address _____
4. Did you have any signs or symptoms preceding the diagnosis? ❑Yes ❑No
   If "Yes", what and when? _____
5. Have you undergone any investigations or tests in connection with your illness? ❑Yes ❑No
   If "Yes", give details. _____
6. Give details of any past and present treatment in respect of your illness. _____
7. Is your current treatment providing any relief of symptoms? _____
8. Have you previously suffered from, or received treatment for, a similar or related illness? ❑Yes ❑No
   If "Yes", give full details. _____

Section C – Record of medical Consultations

1. Please give below the details of any doctors or specialists who have been consulted in connection with your illness

Name	Full Address	Dates Consulted

2. If you were treated at a hospital or similar institution, please supply the following details

Name	Full Address	Date of admission	Date of discharge

3. Please provide the name and address of your usual medical attendant, if different from above.

Name	Address

Section D – Occupational Duties

1. What is your job title? _____
2. Describe your main occupation duties and the percentage of each duty: _____ _____ _____ _____
3. On what date were you first absent from work?
4. Have your ben able to attend to any part of your occupation since this date? ❑Yes ❑No
   If "Yes", provide details. _____ _____ _____
5. How many hours would you normally expect to work during the week? _____
6. Have you any intention of returning to your occupation? ❑Yes ❑No
   If "Yes", when? _____
7. Provide us with a copy of your job description.

Section E – General

1. Are you insured for similar benefits with any other company? If "Yes", give full details including name of company, the amount of benefit and whether or not you have submitted a claim in connection with such insured benefits.	❑Yes ❑No _____ _____ _____ _____ _____ _____

Declaration

I hereby confirm that I am the person referred to above and that I have read over the replies to all questions on this form and that to the best of my knowledge and belief, the information given is true and complete.

Signature(s)

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

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

<u>Attach below documents along with this Claim Form:</u>
Permanent Total Disability / Permanent Partial Disability:

1. Duly Completed Claim Form
2. A Permanent Total Disability Certificate by approved government authority / Board showing percentage of disability.
3. Medical reports and the hospital records showing the nature of disability.
4. Copy of Police Report (if disability is due to an accident or unnatural death).
5. The termination letter from employer showing date and cause of termination from employment.
6. Copy of passport with valid visa page/resident card
7. Original Policy Document assigned to Bank

How to submit this form

<u>To finalize the payment process, we require the submission of the original forms</u>

Mail:
Arabia Falcon Insurance
P.O. Box 2279
Ruwi 112,
Muscat, Oman

Fax:
+968 24566476

E-mail:
info@afic.om