INDIVIDUAL LIFE INSURANCE

CRITICAL ILLNESS & ACCIDENT CLAIM PROCEDURE

Claim Intimation

To register the claim, claimant needs to intimate us within 90 calendar days from the date of the event. To send an intimation, please send an email to life.claims@sukoon.com with the below details. Claim reference number will be sent within 3 working days of receiving the intimation email.

1. Policy number
2. Diagnosis or reason for the illness
3. Date when the illness was diagnosed

Claim Processing

For processing the claim, please send the below documents to life.claims@sukoon.com within 30 days of receiving the claim reference number from us. For any queries or follow up on your settlement, please get in touch with your bank relationship manager.

1. General Documents

- Duly filled claim form
- Duly filled physician statement form filled by the treating doctor
- Medical report from the treating doctor detailing the illness and the treatment provided
- All medical records showing the history of illness
- Copy of passport and visa page

2. Additional Documents

- **Critical Illness:** Duly filled employer statement form
- **Accident:** Police report

Sukoon Insurance PJSC (hereinafter referred to as “Sukoon”) reserves its right to ask for additional documents as may be required and relevant for claim assessment.

Claim Settlement

If the claim is approved, discharge receipt will be sent to the client for confirmation of the claim amount payable within 7 working days of submitting the claim forms and the documents.

The client needs to sign and stamp the discharge receipt. Once this is received, the amount will be transferred to the bank account within 14 working days.

INDIVIDUAL LIFE INSURANCE

CRITICAL ILLNESS AND ACCIDENT CLAIM FORM

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.

1. Details of Policyholder

1. Name	First Name:	☐ *Ms.* ☐ *Mrs.* ☐ *Mr.*
	Family Name:	☐ *Male* ☐ *Female*
2. Policy Number	O I G	
3. Date of Birth		
4. Nature of Job	☐ *Business Owner* ☐ *Employee*	
5. In case of employee, please provide employer address		
Address	Building:	
	Street:	
	PO Box:	
	City:	Country:
6. Telephone		

2. General Details

1. Physician Name	
2. Address	
Date of first visit	

2. General Details (continued)

3. Were you hospitalised?	☐ Yes ☐ No	
If yes, please specify the dates		
4. Were you disabled because of the accident or illness?If yes, please specify the date when you had to stop working because of the event	☐ Yes ☐ No	
5. Have you resumed work?	☐ Yes ☐ No	
If yes, please specify date		
If no, when will you resume work		

3. 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	

4. Illness Details (to be filled in case of Critical Illness only)

1. Date when illness was diagnosed	

5. Bank Details

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

6. Authorization

I hereby authorize Sukoon to wire transfer claim payouts (if any) related to this claim form to the above bank details as filled in 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 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 by signing this form hereby confirm that I am duly legally authorized to fill and claim the policy benefit under the above mentioned policy. I hereby declare that above statements are true in each and every respect. I hereby authorize and provide my unconditional consent to any physician, hospital, insurer, medical information bureau or other organization or person having any records, data or information concerning health history of the deceased life insured to furnish such records, data or information as may be requested by Sukoon or their duly authorized representative to be provided to Sukoon and for Sukoon to further release such received and/or policy and claim related information to any other entity as may be required or requested. I understand that in executing this authorization, I waive the right for such information to be privileged or confidential. I hereby also agree to indemnify and hold harmless Sukoon against all costs, expenses and liabilities which may arise as a result of this claim/claim form including any of the details filled in by me in this claim form. A photocopy of this authorization shall be considered as effective and valid as the original.

Name		Signature		Date	