CRITICAL ILLNESS CLAIM FORM

Statement by Employer

A. DETAILS

Documents Required	Tick
Copy of Employee's Identity document	☐
Certified Employee's Pay slip for the month preceding the diagnosis	☐
Medical reports (e.g medical investigation results, x-ray, etc)	☐
Medical report summary from the attending doctor	☐
Claim application form completed by the employer, employee and attending doctor.	☐

Cannon Life Assurance (K) Ltd reserves the right to call for additional documents where necessary to validate the claim

SCHEME DETAILS

Scheme name: _____

EMPLOYEE DETAILS

Name:_____ Identity Number:_____ Date of Birth:_____

Date of joining employer: _____ Date of Joining scheme:

Monthly salary as at date of diagnosis: _____ Employee's date of diagnosis:

Critical Illness: _____

☐ Cancer ☐ Heart Attack ☐ Coronary Artery Surgery ☐ Stroke

☐ Renal Failure ☐ Blindness ☐ Major Organ Transplant ☐ Paraplegia

B. EMPLOYER'S DECLARATION

I,_____in my capacity as_____and duly authorized to make this declaration, hereby declare:

1. That the information provided in this claim is true and correct, and that no information has been omitted orwithheld
2. That the insured person whose critical illness gave rise to this claim is an employee of the scheme.

I indemnify Cannon Life Assurance against any claim that may arise from any incorrect information provided in this form. Signature_____Date:_____

Telephone Number:_____Email address: _____

Click to Submit

Doctor's Stamp