CRITICAL ILLNESS CLAIM FORM

Statement by Employee

Cannon LIFE ASSURANCE

SCHEME DETAILS

Scheme name: _____

EMPLOYEE DETAILS

Name: _____

Identity Number: _____ Date of Birth: D D M M Y Y Y Y

CRITICAL ILLNESS DETAILS

Date of Diagnosis: D D M M Y Y Y Y

Critical Illness: _____

☐ Cancer ☐ Heart Attack ☐ Coronary Artery Surgery ☐ Stroke

☐ Renal Failure ☐ Major Organ Transplant ☐ Paraplegia ☐ Blindness

Date of first symptoms: D D M M Y Y Y Y

Date of first consultation with a doctor: D D M M Y Y Y Y

Name of Attending Doctor: _____

Have you ever had the same or similar condition? _____ (If yes state when and describe)

_____

_____

_____

Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc.) consulted in connection with this illness.

NAME	SPECIALITY	CONTACT DETAILS	DATE

EMPLOYEE'S DECLARATION

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Employee's Full Names: _____

Signature_____ Date: D D M M Y Y Y Y

Cannon Life Assurance (K) Limited

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Regulated by the Insurance Regulatory Authority

Cannon
LIFE ASSURANCE

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