سلامة
SALAMA
الشركة الإسلامية العربية للتأمين (ش.م.ع.)
ISLAMIC ARAB INSURANCE CO.(P.S.C.)

Claim Form

Covered Member Details:

Plan No.: _____

Name: _____

Date of Birth: _____

Sex: *Male* ☐ *Female* ☐

Address: _____

Contact Nos: _____ Email Id: _____

Claim Details:

Type of Claim : *Death* ☐ *Disability* ☐ Permanent or Partial

Critical Illness ☐ *Medical Expenses* ☐

Repatriation Benefit ☐ _____

Date of Event/Loss: _____

Claim Amount: _____

Description of the Event:

_____

_____

Death/Disablement Claims/Critical Illness *(to be completed by the Insured /Customer)*

1. Date when the insured was first examined by a doctor for the condition that caused Death/disablement/Critical Illness/Injury: _____
2. Was death/disablement/Critical Illness due to Sickness? ☐ Accident? ☐
3. Date when the Insured had noticed the initial symptom _____
4. Name and Address of the Family Doctor :

   _____

   _____

Authorisation: I hereby authorise any physician, hospital, insurer, Medical Information Bureau or other Organisation or person having any records, to provide data or information as may be requested by Islamic Arab Insurance Co. - SALAMA or their duly authorised representative. I understand that in executing this authorisation, I waive the right for such information to be privileged. A photocopy of this authorisation shall be considered as effective and valid as the original.

Date_____ Signed _____

Address_____