GROUP LIFE INSURANCE

DISABILITY 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 your application 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 proposal form and other correspondences with us for your future reference.

1. Policy and Employee Details

1. Policy Number	O I G
2. Company Name	
3. Sub-Company Name (if applicable)	
4. Sum Insured	
5. Currency	

2. Employee Details

1. Employee Name			
2. Date of Birth		*Gender*	☐ *Male* ☐ *Female*
3. Employment Status	☐ *Temporary* ☐ *Permanent*	*Employee Number*	
4. Work Location		*Date of Joining*	
5. Designation			
6. Salary with breakup (Basic + Allowance)			
7. Date of Event		*Place of Event*	
8. Cause of Disability	☐ *Accident*	☐ *Sickness*	
9. Diagnosis			
10. Treatment Details			
11. For Disability due to sickness, please specify when was the condition first diagnosed			

3. Benefits Claimed (please tick whatever applies as per your policy)

1. ☐ *Permanent Total Disability/Permanent Partial Disability* — *Disability Percentage* ____
2. ☐ *Temporary Total Disability*
3. ☐ *Accidental Medical Expenses*

4. Policyholder Bank Details

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

5. Temporary Total Disability – Sick Leave Details (if applicable)

1. Leave Start Date ____ *End Date* ____

2. Please provide details of any intermittent sick leaves taken.

From	To	Reason

6. Accidental Medical Expenses (if applicable)

1. Please provide details of all the medical expenses. Use additional sheet if required.

Service Description	Provider Name	Currency	Claimed Amount

7. Claimant Declaration

I hereby declare that the particulars mentioned above are true and correct to the best of my knowledge.

1. Name	
2. Designation	
3. Signature	
4. Date	
5. Stamp	

8. Beneficiary or Legal Representative Declaration

I hereby authorize Oman Insurance Company P.S.C. (hereinafter referred to as “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		Date	
Signature		Relation with Insured	