

## 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](mailto: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](mailto: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

Oman Insurance Company P.S.C. ("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: <input type="text"/> <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. Family Name: <input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female
2. Policy Number	O I G <input type="text"/>
3. Date of Birth	<input type="text"/>
4. Nature of Job	<input type="checkbox"/> Business Owner <input type="checkbox"/> Employee
5. In case of employee, please provide employer address	
Address	Building: <input type="text"/> Street: <input type="text"/> PO Box: <input type="text"/> City: <input type="text"/> Country: <input type="text"/>
6. Telephone	<input type="text"/>

2. General Details	
1. Physician Name	<input type="text"/>
2. Address	<input type="text"/> <input type="text"/> <input type="text"/>
Date of first visit	<input type="text"/>



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## 2. General Details (continued)

3. Were you hospitalized  Yes  No

If yes, please specify the dates

4. Were you disabled because of the accident or illness?  Yes  No

If yes, please specify the date when you had to stop working because of the event

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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

6. TName and Address of Police Station where accident was reported

