



4.1 DREAD DISEASE CLAIM FORM (Insured part)

DREAD DISEASE CLAIM FORM
TO BE COMPLETED BY THE INSURED

Policy Number:

Name of Insured:		I.D. No.
Residence Address:		Telephones:
Work Address:		Telephones:
Disease Details:		
Date of the Disease commencement:		
Diagnosis:		
First symptoms and when firstly appeared:		
Did you ever receive any treatment in a Hospital/Clinic for this disease? If YES, When and Where?		
Who are your treating doctors and since when do they treat you?		
Name/Specialty	Address/Telephone	Date
Have you or do you receive other benefits for the same illness by other insurance company or other organization?		
Laboratory Examinations and Results:		
Type of Examination	Date of Examination	Results

TO PROCEED WITH THE EXAMINATION OF YOUR CLAIM, THE LABORATORY TEST RESULTS SHOULD BE SUBMITTED

DECLARATION:

I hereby declare, knowing the consequences of the law, that all the above statements are true and complete. I authorize **Gan Direct Insurance Ltd** to ask and take by any doctor, medical institution and insurance company, information and reports in respect of my mental and physical condition.

Insured's Signature.....Date.....

Warning: All supporting documentation (originals) must be provided along with the claim forms

Supporting Documentation for dread disease claim

1. Claim Forms (Fully completed) (Within 6 months from the date of the Diagnosis)
2. Medical Expert's Advice
3. Hospital's/ Clinic's advice if insured has been hospitalized
4. Laboratory tests or any other diagnostic examinations done, together with their outcomes
5. Medical history
6. Photocopy of the Medical booklet (If applicable)