ADNIC

شـركـــة أبوظبـــي الوطنيـــة للتأميـــن
ABU DHABI NATIONAL INSURANCE COMPANY

GROUP LIFE, ACCIDENT, ILLNESS AND MEDICAL EXPENSES (CLAIM FORM)

Policy No.....

Employer's reference.....

EMPLOYER'S Name .....

THE CLAIMANT

1. Full Name ..... 2. Occupation .....
3. Nationality.....4. Age..... 5. Male/Female..... 6. Marital Status.....
7. Basic Salary..... per month

THE ACCIDENT/SICKNESS

1. Date and time of accident or date sickness commenced.....
2. Where it occurred .....
3. Nature of injury/sickness .....
   .....
4. Brief description of how it happened .....
   .....
5. Name of doctor in attendance .....
   Address .....
6. If claiming accident benefit state period totally unable to attend to normal duties..... from..... to
   .....
7. If claiming sickness benefit, have you suffered previously from this complaint YES Or NO. If YES please give details
   .....
   .....
8. Are you entitled to claim from any other source YES Or NO. If YES please give details
   .....

Details of expenses:

Nature of expenses	Amount
(a)	(a) .....
(b)	(b) .....
(c)	(c) .....
(d)	(d) .....

All available accounts in support of this claim should be attached

Declaration

I, the undersigned, hereby declare that the above answers are in every respect true and complete.

I hereby authorize the Company to apply to my medical attendant or any other doctor from whom treatment was received for a medical report.

Signature

Date .....

The Insured or his Representative