Jubilee INSURANCE

Critical Illness Claim Form

(To be completed by the claimant)

Claimant's name _____ Date of birth _____

Name of Employer _____

Address _____

Telephone number _____

Please advise the diagnosis of the condition for which you are claiming benefit _____

When did you first experience symptoms related to this condition _____

Please provide details of the initial symptoms _____

When did you first consult a doctor in relation to these symptoms _____

Please provide details of any hospital investigations or tests which have been carried out to determine the diagnosis and extent of your condition. _____

Have you previously suffered from or received treatment for a similar or related illness? Yes ☐ No ☐
If yes, please provide details and include relevant dates _____

Please provide the name of your General Practitioner. If you have changed doctors in the last 12 months please also provide the name of the GP with whom you were previously registered

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Please provide the name(s) of any consultant(s) you have attended in connection with this condition.

Name	Hospital	Date

Please provide the name and address and type of other healthcare professional you have seen in connection with this illness

Do you hold any policies with any other insurance companies which provide you with similar cover Yes ☐ No ☐

If yes, please detail below

Please provide any further information which may be of assistance to us in assessing this claim

The information provided above is correct to the best of my knowledge

Signature _____ Date _____