

Credit Shield & Life Insurance Claim Form

Please complete this form in BLOCK LETTERS

Card Member Details

Customer name:

Address:

Date of Birth: / / Male Female

Tel.No. Fax No:

Mob. No.: Email:

Card Type: Visa MasterCard

Card category: Silver / Classic Gold Platinum Business Corporate

Credit card 1: Date of Issue : / / Valid through: / /

Credit card 2: Date of Issue : / / Valid through: / /

Credit card 3: Date of Issue : / / Valid through: / /

Claim Details

Type of claim: Death (Accidental / Natural / Others) Permanent total disablement
 Hospital cash benefit Involuntary loss of employment

Date of the event: / /

Description of the event:

Death / Disablement Claims (to be completed by the Cardmember / Cardmember's authorized representative)

1. Date when the Cardmember was first examined by a doctor for the condition that caused death / disablement: / /

2. Was death / disablement due to illness? Accident?

3. Name and address of the family doctor (If you have one)

Involuntary Loss of Employment (to be completed by the Cardmember)

1. Name and address of the Company where you were an employee:

Tel. No. Fax No.

Email:

2. Employee ID: Designation:

Department: Location / Branch:

3. Date of Notice of Unemployment: / /

4. Details of any Notice Pay received: Amount: Period from / / to / /

5. Reason for termination:

To avoid your claim being void, please inform Dubai First as soon as you accept a new job. We reserve the right to recover the full amount paid under the terms on the insurance since the beginning of his unemployment should you fail to inform us of a new job.

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Disclaimer

I hereby declare and agree that the information provided above are true and undertake to inform Dubai First/Oman Insurance Company immediately upon taking an employment either temporary or permanent. I understand that failure to notify the Dubai First/Oman Insurance Company of taking an employment within 15 days of employment shall render my benefits/claims paid/payable void and recoverable from me including the benefits/claims paid for the actual period of unemployment.

Date: / /
DD MM YY

Signed: _____

Authorisation

I hereby authorise any physician, hospital, insurer, Medical Information Bureau or other Organisation or person having any records, to provide data or information as may be requested by Oman Insurance Company or their duly authorised representative. I understand that in executing this authorisation, I waive the right for such information to be privileged. A photocopy of this authorisation shall be considered as effective and valid as the original.

Date: / /
DD MM YY

Signed: _____

Please attach the following documents (original may be required for verification)

For Death Claims

- i. Death certificate issued by a competent authority in the relevant jurisdiction.
- ii. Post mortem report (wherever legally required).
- iii. Police report (if death was due to an accident).
- iv. Medical report* with detailed diagnosis and cause of death if required by the Company when actual cause of death is not clearly mentioned in the death certificate.
- v. Copy of passport with visa page
- vi. Any other documents as may be required

For Permanent Total Disablement Claims

- i. Disability certificate from an authorised medical practitioner to assess disability.
- ii. Police report (if disability is due to an accident).
- iii. Medical report* with detailed diagnosis, cause of disability and details of treatment given.
- iv. Copy of passport with visa page.
- v. Any other documents as may be required

For Hospital Cash Benefit Claims

- i. Police Report if applicable
- ii. Medical Report from a licensed and registered medical officer
- iii. Discharge Summary.
- iv. Any other documents as may be required

For Involuntary Loss of Employment Claims

- i. Notice of termination from the Cardholder's employer (the "Employer").
- ii. Copy of passport with visa page
- iii. Credit card statement for 3 months preceding date of notice of termination
- iv. Any other documents as may be required

The Company may also request for a copy of the labour contract from Employer if it is required to verify the period of employment contract.

* From an Authorised Medical Practitioner

All papers as indicated above may be required to be produced in original (other than those surrendered to the authorities or Employer) for verification before the final settlement of claim.

IMPORTANT NOTICE:

1. Send the claim along with the required docs within 10 days from the day of the event.
2. Claim response time; Insurance will require 45 days to respond.
3. Rejected/declined claims; claims which will not be processed and will be declined upfront due to the reason of termination, etc and we may refer the same to our T&C with the clause number.
4. Please submit the completed Claim Form along with the required documents to Dubai First.

Please fax this application to 04 - 506 8423

Terms & conditions apply.

For Dubai First use only:

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Request received by : _____

Date request received : / /
DD MM YY

Request processed by : _____

Date request processed : / /
DD MM YY