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STAY AHEAD

Credit Shield and Life Insurance Claim Form

Please complete this form in BLOCK LETTERS

Card Member Details

Customer name:

Address:

Date of Birth: ____/____/____ (DD MM YY) ☐ Male ☐ Female

Tel.No. Fax No:

Mob. No.: Email:

Card Type: ☐ Visa ☐ Mastercard

Card category: ☐ Silver / Classic ☐ Gold ☐ Titanium ☐ Platinum ☐ Infinite ☐ Business

Credit card 1: XXXXXX Date of Issue : ____/____ (MM YY) Valid through: ____/____ (MM YY)

Credit card 2: XXXXXX Date of Issue : ____/____ (MM YY) Valid through: ____/____ (MM YY)

Credit card 3: XXXXXX Date of Issue : ____/____ (MM YY) Valid through: ____/____ (MM YY)

Claim Details

Type of claim: ☐ Death (Accidental / Natural / Others ☐ Permanent total disablement

☐ Hospital cash benefit ☐ Involuntary loss of employment Date of the event: ____/____/____ (DD MM YY)

Description of the event:

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

1. Date when the Cardmember was first examined by a doctor for the condition that caused death / disablement: ____/____/____ (DD MM YY)
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: ____/____/____ (DD MM YY)
4. Details of any Notice Pay received: Amount: Period from ____/____/____ (DD MM YY) to ____/____/____ (DD MM YY)
5. Reason for termination:

To avoid your claim being void, please inform First Abu Dhabi Bank (FAB) 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 your unemployment should you fail to inform us of a new job.

Credit Shield & Life Insurance Claim Form

Disclaimer

I hereby declare and agree that the information provided above are true and undertake to inform FAB/Oman Insurance Company immediately upon taking an employment either temporary or permanent. I understand that failure to notify FAB/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 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 FAB.

Email this application to contactus@dubaifirst.com

Terms & conditions apply

For official use only:

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Request received by : _____

Date request received : _____/_____/_____ (DD MM YY)

Request processed by: _____

Date request processed : _____/_____/_____ (DD MM YY)

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FORM/CS&LIC/E/28062020