Forte
Life Assurance

CLAIM FORM
GROUP TERM LIFE INSURANCE POLICY

Important Note:
This claim form is issued by Forte Life Assurance (Cambodia) Plc., without any admission of liability and must be returned to us upon completion of this claim form. To safeguard your interest, please ensure that you complete and return this form with the supporting documents within 30 (thirty) days as it is a condition for us to examine the claim and determine our liability.

Section 1 – Detail of the Insurance Policy

Policy Number	Policyholder Name
…………………………	…………………………

Address (Head Office/Branch)
…………………………………………………………

Authorized Person Name	Position	Contact Number
…………………………	…………………………	…………………………

Section 2 – Details of The Insured Person

Insured Person Name	Sex	Date of Birth	Age
…………………………	…………	…………………………	…………

Occupation	Date of Employment
…………………………	…………………………

Residence Address
…………………………………………………………

Section 3 – Detail of Claim

Claim Type	Cause of Loss
☐ Death ☐ TPD (Total and Permanent Disability) ☐ PPD (Partial and Permanent Disability)	☐ Illness ☐ Accident

If the cause is resulted from Illness, kindly complete the section (**A**)
If the cause is resulted from accident, kindly complete the section (**B**)

A – About the Illness:

Specific Diagnosis	Date of Loss
…………………………	…………………………
Admission Date	Discharge Date
…………………………	…………………………

Last Date of Consultation	Name of Hospital/Clinic	Contact Number
…………………………	…………………………	…………………………

Hospital/Clinic Address
…………………………………………………………

Place of Loss
…………………………………………………………

Did the insured person used to take medical leave consecutively for more than 2 weeks? If yes, please provide the details below

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How long has the Insured Person gotten the symptoms?

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Does the insured person regularly have the medical check-up? Please provide the details below.

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Descript the symptoms and event 6 hours before time of loss.

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Descript the condition of the Insured Person after discharge from the hospital/clinic

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B – About the Accident

Cause of Accident	Date of Accident	Date of Loss
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Place of Accident

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Name of Hospital/Clinic	Contact Number
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Hospital/Clinic Address

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Admission Date	Discharge Date
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Please describe the situation of the Insured Person after discharge from hospital/clinic

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Important Note to the Detail of Claim:
The Claimant or the Policyholder shall attach herewith the medical report, including but not limited to, Medical Certificate or Report, Original Invoices/Receipts, Prescriptions, Test Results (CT Scan, X-Ray, MRI, Lab Test, Echo, ECG, etc.) and other documents required by us that is related to illness or accident.
The police report shall be provided in the event of the accident or any required from the Company.

Details of the Beneficiary

Please provide the details of beneficiary below;

Beneficiary Name	ID/Passport No.	Relation	Contact Number
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Residence Address

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Declaration of the Policyholder

By signing below, we acknowledge and confirm that:

- All information we have given is true and complete to the best of our knowledge and belief;
- Background of the named beneficiary has been checked and confirm the legitimate of the beneficiary of the insured person;
- Authorization to the Company to use the information given herein as required by competent authority and/or regulation in-force;

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or claim containing any Materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime.

Signature/Stamp of the Authorized Person of the Policyholder

Name:
Position:
Date: