

COMPREHENSIVE PERSONAL PLAN CLAIM FORM
THE ISSUE OF THIS FORM IS NOT TAKEN AS ADMISSION OF LIABILITY
(Note: Additional information or Documents may be called for if necessary)

Name of Policy Holder			
Policy Number		Period of Insurance:	No:
Name of the Life Assured			
ID/Passport Number:		Tel. No./ GSM	
Nationality		Occupation	
Age / Date of Birth		Nature of Work	
Nature of Claim			
<input type="checkbox"/>	Death	<input type="checkbox"/>	Accidental Death Benefit (ADB)
<input type="checkbox"/>	Repatriation	<input type="checkbox"/>	Permanent Partial Disability (PPD)
<input type="checkbox"/>		<input type="checkbox"/>	Permanent Total Disability (PTD)
<input type="checkbox"/>		<input type="checkbox"/>	Medical Expenses due to Accident
<input type="checkbox"/>		<input type="checkbox"/>	Temporary Total Disability (TTD)
ACCIDENT/SICKNESS			
Date of Accident/Sickness			
Details of Accident / Sickness:			
Nature of Injuries			
Claim amount			
GENERAL			
Are you insured against accident with any other Company? If so, give name and amount of benefit.			
Have you previously suffered from trouble or any other injury? If so, give particulars with date and period of incapacity			
Have you previously made any claim under this or other accident policies? If so, give details			
To be completed for Permanent / Temporary Disablement Compensation Claims only			
Date on which ceased working			
Have you ever since been able to supervise or give any attention whatever to any part of your business or occupation? If so, from what date			
Date on which resumed working			
Annual Salary at time of accident (to be supported by a certificate from Employer)			

I hereby warrant the truth of the above statements

Date:

Signature of Insured

Liva Insurance SAOC

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س.ت: ٢٣ / ١٤٨٧٧٧ رقم التأمين: ٢٣