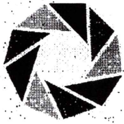

PRIME INSURANCE CO. LTD.
HEAD OFFICE, DHAKA.
CLAIMS DEPTT

DREAD DISEASE CLAIM FORM

(Issuance of this form does not imply admission of liability by the insurer)

01. Name of Insured :

02. Policy No. :

03. Period : From -------------------------- To ----------------------------

04. Depositor's Name, Address & Last Occupation :

05. Deposited Amount with date : Tk.

06. Name of Deposited Branch :

07. Date of Birth of Depositor :

08. Direct Cause of Death :

09. Place of Death :

10. Date of Death :

11. Name of Claimant :

12. Name of Nominee (s) :

13. How Long the depositor suffered from the disease which caused his/her death with proper documents in original :

14. Date and Name of Hospital/ Clinic of last admission of the depositor :

15. Date of admission into Hospital/Clinic :

16. Name & Address of Last attending Physician :

17. Please attach copies of prescription for last two years before his/her death :

18. Date of reporting of illness :

I/we hereby declare that we have furnished full informations against the above queries. The informations as furnished above are correct. If it is found that I/We have made fraudulent or suppression or concealment of facts relating to the death of the Depositor, all of my/our rights of recovery of claim from the Insurer will be prejudiced.

Countersignature of the Branch Manager

Seal

Date :

Signature of the Nominee(s)

Date :