TERMINAL ILLNESS CLAIM FORM

INFORMATION OF THE INSURED

Name of the Insured: Policy Number: _____

First Name	Middle name	First Last Name	Second Last Name
_____	_____	_____	_____

Identification Number: _____ Date of Birth: dd / mm / yy

Address of the Insured: _____ Phone Number: _____

City	State	Country	Postal Code
_____	_____	_____	_____

Occupation: _____ Employer: _____

Policy Owner (if different than the Insured): _____

MEDICAL INFORMATION

1. What is the exact name / diagnosis of your illness? _____

2.Information of the doctor who determined the above.

NAME	SPECIALTY	ADDRESS	EMAIL	PHONE

3.When was this first diagnosed? dd / mm / yy

4.When were the symptoms of this illness first manifested? dd / mm / yy

5.Have you ever suffered from a similar or related illness? **YES** ◯ **NO** ◯

6.List tests/ investigations for this condition with dates.

NAME OF TEST	CLINIC/HOSPITAL OR LABORATORY WHERE TEST WAS PERFORMED	DATE

7.Details of any surgery or biopsy performed:

TYPE OF SURGERY	CLINIC/HOSPITAL OR LABORATORY WHERE TEST WAS PERFORMED	DATE

8.Details of other treatment (e.g. radiation therapy, chemotherapy, medication, etc.):

T YPE OF TREATMENT	CLINIC/HOSPITAL OR LABORATORY WHERE TEST WAS PERFORMED	DATE

9.List all doctors you have seen for this illness.

NAME	SPECIALTY	ADDRESS	EMAIL	PHONE

Please include the following documents:

1. Copy of reports of all medical exams performed since the date of the original diagnosis.
2. Name and contact information of any other physician who has participated in your care.

CERTIFICATION AND AUTHORIZATION

I certify that the previous statements are true and complete to the best of my knowledge and beliefs.

I authorize the doctors, hospitals, and any medical provider to provide to Olé Insurance Group Corp. I.I. any medical reports and medical history that requests (that may include information on mental diseases, use of drugs, addictions and previous illnesses), in order to be able to assess the claim.

Signature of Insured: _____ Date: dd / mm / yy

Signature of Policy Owner
(if different than insured): _____ Date: dd / mm / yy

Notice: Any person who knowingly and with the intent to harm, defraud or mislead an insurer, files a claim statement that contains any false, incomplete or misleading information may be guilty of insurance fraud and subject to civil and criminal penalties.

Is there an assignment of the policy? YES ◯ NO ◯

POLICY OWNER'S BANKING INFORMATION

Account holder name: _____

Name of Bank: _____ Phone Number of Bank: _____

Address of Bank: _____

SWIFT/ABA: _____ Account Number: _____

Type of Account (Savings/Checking): _____