



Credit Shield Insurance - Claim Form

Cardholder Name:	
Card Number:	
Cardholder's date of birth:/(dd/mm/yyyy)	
Type of Card : Silver $oxtimes$ Classic $oxtimes$ Gold $oxtimes$ Platinum $oxtimes$ Infinite $oxtimes$	
Credit Limit AED: Outstanding Limit AED:	
Name of claimant:	
Relationship to the Cardholder:	
Tel No: Mobile:	
E-mail:	
Benefit Details: Natural Death	
1 .Date of Death :	
2 .Cause of Death:	
3 .Name of Doctor and Hospital:	
Other Insurance: Please Complete this section in full to avoid delaying your Claim Settlement	
Do you have any other insurance that will cover this loss: YES \square NO \square If yes, please give the name and address of your Insurer:	
Declaration:	
I declare to the best of my knowledge and belief that the above statements are true. I understand that if I provided any information that is not true, my claim will not be covered, and I may suffer consequences the	
Signed: Date:	

For assistance, please contact ADNIC on +971 2 408 0551