# Adult Critical Illness Insurance Consent Form

## Policyholder Information

Full Name

Date of Birth

Contact Number

Email Address

Residential Address

## Consent Declaration

I hereby give my voluntary consent to apply for Adult Critical Illness Insurance coverage. I acknowledge that I have reviewed and understood the terms, conditions, and exclusions of the policy. I authorize the insurance provider to collect, use and disclose my personal information as required for processing my application and administration of the insurance policy.

## Medical Information Consent

I consent to the insurance company obtaining, using, and sharing my personal and medical information with healthcare providers and any other relevant third parties for the purpose of underwriting and claims assessment.

## Additional Notes (Optional)

Enter any additional information relevant to your application...

## Signature

Signature of Applicant

Sign or type your name

Date

Place

By signing above, I confirm the accuracy of all information provided and that I have read and understood all statements and disclosures in this consent form.