CLAIM FORM FOR DISABILITY BENEFITS

Note:

- The issue of this claim form does not imply an admission of liability by the Company.
- The policyholder is responsible for the payment of any fees in connection with the completion of this form
- Only a fully completed and signed claim form can receive our further attention
- If disability is the result of an accident, please complete sections 1, 2, 4, and the Declaration, and have section 5 completed by the doctor.
- If disability is the result of an illness, please complete sections 1, 3, 4, and the Declaration, and have section 5 completed by the doctor.

Section 1 - General Information

Policy Number ………………………………………….. Effective Date ……………………………….

Name of Policyholder …………………………………………………………………………………….

Name of Claimant (in full) ……………………………………………………………………………….

Date of Birth ……………………………………………Relationship to Policyholder ………………...

Postal address ……………………………………………………………………………………………..

………………………………………………………… Telephone number (daytime) ……………….

Name of Claimant's usual doctor ………..……………………………………………………………….

Postal address ……………………………………………………………………………………………...

Telephone number ………………………………….…Fax number ……………………………………..

Name and postal addresses of any other medical practitioners who have treated the claimant for this injury or illness

…..……

…..……

Section 2 - Details of the Accident

The accident occurred at ……………………………………………………………………(Place)

on ……………………………………………………………………(Date)

at ……………………………………………………………………(Time)

Name of Police Station where accident was reported ……………………………………………….

Postal address ……………………………………………………………………………………

……………………………………………………………………………………………………

Describe as fully as you can, how the accident happened

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

If it was a motor accident, please attach a copy of the Road Traffic Collision report

Section 3 - Details of the Illness

Brief description of the illness ……………………………………………………………………..

……………………………………………………………………………………………………

Date when symptoms first appeared ………………………………………………………………

Date when you first consulted a doctor for this illness ……………………………………………….

If you have suffered from this illness before, please give the dates

……………………………………………………………………………………………………

Section 4 - Details of the Claimant's occupation

Name of employer ……………………………………………………………………………….

Postal address ……………………………………………………………………………………

Telephone number ……………………………………….Fax number ……………………………..

Your job title ……………………………………………………………………………………

Brief description of your normal duties

……………………………………………………………………………………………………

……………………………………………………………………………………………………...

Section 4 - Details of claimant's occupation (continued)

Please give details of the previous three positions held.

Dates …………………………………………….. Name of Employer ……………………………………

Job title and brief description of duties ………………………………………………………………
……...

Dates …………………………………………….. Name of Employer ……………………………………

Job title and brief description of duties ………………………………………………………………
……...

Dates …………………………………………….. Name of Employer ……………………………………

Job title and brief description of duties ………………………………………………………………
……...

DECLARATION

I hereby declare and warrant that the information given in this claim form is in every respect complete and true.

I authorise any medical practitioner, hospital or other person to provide Flexible Accident & Sickness Acceptances with any information they may require relating to my medical history and the injury or illness to which this claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original.

Signed by the claimant or his/her legal representative ……………………………………………………

Name (please print) ……………………………………………………. Date ……………………………

The claimant or policyholder must obtain, at his or her own expense, the following report from a duly qualified and registered medical practitioner, who is not a member of the policyholder's immediate family.

Section 5 – Medical Attendant's Report

Full name of patient ………………………………………………………………………………………..

Age ……………………………………….. Height ………………………. Weight ………………………

When were you first consulted about this injury or illness ………………………………………………..
Are you still in attendance Yes/No

If disability is due to an accident, what injuries were sustained ……………………………………...…
………
………

If disability is due to an illness, please describe fully the nature and extent of the illness ……………………
………
………

Section 5 – Medical Attendant's Report (continued)

Is the patient's disability due to:

- The illness or accident alone Yes/No
- Some other cause in addition to the illness or accident Yes/No if Yes, please give details

………
………
………

Are you aware of anything in the patient's previous medical history which may have contributed to the occurrence of the illness/accident, or which may be likely to retard recovery? If so, please give details

………
………
………

Can you certify that the patient is or has been totally unable to follow his/her occupation? Yes/No

If so, when did he/she first become unable to follow his/her occupation? …………………………………….

Is the patient able to attend to a portion of his/her occupation? Yes/No

If so, when did he/she become able to do so? ………………………………………………………………….

When did, or will, the patient become able to resume his/her occupation? …………………………………..

Please give any further information which you think may be of help to us in considering the patient's claim for disability benefits.

………

………

………

……………………………………………… ………………………….

Signature of medical attendant ***Date***

MEDICAL ATTENDANT'S DETAILS

Name …………………………………………………. Qualifications ………………………………….

Postal Address ………………………………………………………………………………………………

…………………………………………………... Telephone number ……………………………..