

CLAIMANT'S STATEMENT FOR ACCIDENT & SICKNESS BENEFITS

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

PART A - COMPLETE IN FULL

1. Full Name (Please Print) _____		9. Give date and hour when accident (or beginning of illness if disability Claim) occurred? Day _____ Month _____ Year _____ _____ at _____ o'clock M. _____	
2. Policy Number _____	3. Age _____	10. On what date did you stop performing all your occupational duties? Day _____ Month _____ Year _____ _____	
4. Height _____	5. Weight _____		
6. Residential Address _____ ID# _____ Tel# _____		11. Have you done any work since commencement of disability? If yes, explain _____	
7. Business Address No. _____ Street _____ City _____ Country _____ Employer _____ Nature of Business _____			
8a. Occupation _____	8b. Average Earnings per Week _____	12. How do you spend your time? _____	
8c. Describe Duties _____			
16. Bank _____ Branch _____ Account # _____ Email Address _____		13. Confined to house from _____ to _____	
		14. Confined to hospital from _____ to _____	
17. Give date consulted and Name and Address of every Physician consulted by you on account of present condition Day _____ Month _____ Year _____ Name _____ Address _____ _____ _____ _____		15. When do you expect to return to work? Day _____ Month _____ Year _____	
		18. What other Life, Health or Accident Insurance providing for disability benefits have you? Name of Company _____ Address _____ Amount of Weekly Indemnity _____ _____ _____	

PART B - COMPLETE FOR ACCIDENT CLAIM ONLY

A. What bodily injuries did you sustain wholly by the Accident? _____
B. Where and how did the Accident occur? _____
C. If partial disability is claimed state the particular duties you were unable to perform during the entire period of partial disability? _____
D. Were you on vacation or unemployed during any period of disability? _____
E. Has disability resulting from Accident ended and is this your full claim? _____
F. How long were you totally disabled _____ (weeks) _____ (days)
G. How long were you partially disabled _____ (weeks) _____ (days)

PART C - COMPLETE FOR SICKNESS CLAIM ONLY

A. Describe fully your present conditions _____
B. Has any member of your family been afflicted with a similar disease? _____
C. Have you seen a Physician within the last three years for reasons other than your present condition. If yes give reasons, date, name & address. _____
NOTE: This Blank form is furnished to the Insured without prejudice to or waiver of any right of defense that the Company may have relative to any claim filed hereunder

NB.
All expenses must be supported by detailed bills. Only original bills are acceptable. Hospital Bills should state the number of days spent and the charge for each day as well as itemized charges for other hospital services; drug bills should show the date of purchase, prescription number, name of patient, name of doctor, name or type of drugs and cost. Bills for x-rays should show the date, patient's name, and the charges.

The foregoing statements are full and true to the best of my knowledge and belief, and I agree that payment according to the terms of the policy, for the period of disability as herein indicated, should be in full satisfaction and discharge of any and all claims, the cause of which originated prior to the date hereof.

I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person that has any records or knowledge of my family or me, to give to **Pan-American Life Insurance Company of Trinidad and Tobago** any and all information about my family members or me with reference to our finances, our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I also authorize **Pan-American Life Insurance Company of Trinidad and Tobago** to provide the information derived from this application and any other existing record, to service providers and related third parties in order to evaluate any insurance proposal request made by me and for the purposes of administration of this policy.

A photographic copy of this authorization shall be as valid as the original.

(witness)

Signed _____
Date _____ Day _____ Month _____ Year _____

**ATTENDING PHYSICIAN'S STATEMENT
-ACCIDENT AND SICKNESS-
THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**

Patient's name _____	Age _____
1. Nature of sickness or injury. (Describe complications if any)	
2. Is condition due to pregnancy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. If "yes" what was approximate date of commencement of pregnancy?	Date _____
4. If fracture or dislocation, state whether complete or incomplete.	<input type="checkbox"/> Complete <input type="checkbox"/> Incomplete
5. If fracture of long bones, state whether fracture is through shaft or extremity.	<input type="checkbox"/> Shaft <input type="checkbox"/> Extremity
6. Was it confirmed by X-ray?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. When did symptoms first appear or accident happen?	Date _____
8. When did patient first consult you for this condition?	Date _____
9. Has patient ever had same or similar condition? (If "yes" state when and describe)	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Describe any other disease or family infirmity affecting present condition.	
11. *Nature of surgical or obstetrical procedure, if any (Describe fully)	
12. Give dates of treatment.	<div style="text-align: right; margin-bottom: 5px;">Charge per call</div> Office _____ \$ _____ Home _____ \$ _____ Hospital _____ \$ _____
13. Is patient still under your care for this condition? If discharged, give date.	Yes <input type="checkbox"/> No <input type="checkbox"/> Date discharged _____
14. If patient hospitalized, give name and address of hospital.	Hospital _____ _____ City _____ State _____ _____ Date Admitted _____ Date Discharged _____
15. How long was patient totally disabled (unable to work)?	From _____ through _____
16. If sickness, was patient confined to the house? (If "yes" give dates).	Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ through _____
17. Is condition due to injury or sickness arising out of patient's employment? (If "yes" explain).	Yes <input type="checkbox"/> No <input type="checkbox"/>

REMARKS:

I HEREBY CERTIFY THAT MY ANSWERS TO THE FOREGOING QUESTIONS ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date _____ SIGNATURE _____ Physician or Surgeon

(Print or type name)

Office Address

Pan-American Life Insurance Company of Trinidad and Tobago

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