Sagicor

PERSONAL ACCIDENT
Claimant's Statement of Disability

Basis of Claim

Accident ☐

Disability ☐

_____
Full Name of Insured

_____
Policy Number(s)

_____ _____ _____
Date of Birth Height Weight

State your average weekly earnings

_____

Home Address _____
_____

Name of Workplace _____

Address of Workplace _____
_____

Nature of Business _____

Your Occupation _____

Describe your duties _____
_____

List all **Other Policies** with any other company which provide disability or health insurance

Name of Company	Amount and type of Benefit
_____	_____ _____
_____	_____

Details or every Physician regarding your current condition.

Date	Name of Physician	Address of Physician
_____	_____	_____
_____	_____	_____

If Claim is for Accident Disability

Where did it occur?_____
_____
_____

How did it occur? _____
_____
_____

What bodily injuries did _____
you sustain caused wholly _____
by the accident? Is there _____
visible evidence of contu- _____
-sion or wound? Describe. _____
_____
_____

If Claim is for Illness Disability

Describe fully your present condition
_____
_____

Has any member of your family been affected with a similar disease?
_____
_____

Have you seen a physician within the last 5 years for reasons other than your present condition? If yes, give reasons, dates, names and addresses.
_____
_____
_____
_____

Date and Hour of beginning of accident of illness _____ On what date did you stop performing your occupational duties? _____. If partial disability is claimed, state the duties you were unable to perform during the entire period of partial disability _____. Have you done any work since commencement of disability? If yes , explain _____. Were you on vacation or unemployed during any period of disability? If yes explain and give dates. _____

How do you spend your time? In hospital from _____ to _____ How many days were you totally disabled? _____

At home from _____ to _____ How many days were you partially disabled? _____

When do you return to work? _____ Is this your full claim? _____

Declaration

I hereby authorize any person who has employed me to give full details of my employment, including my salary and duties, to Sagicor Life Jamaica Limited. I also authorize and direct every physician, surgeon or other person and every hospital & institution to disclose fully to Sagicor Life Jamaica Limited or its duly appointed representative any knowledge or information such person or institution may possess concerning my health and medical history.

I hereby declare that the foregoing statements are full and true to the best of my knowledge and belief, and I agree payment according to the terms and conditions of the policy contract, for the period of disability herein, shall be a full satisfaction and discharge of any claims the cause of which originated prior to the date hereof.

_____	_____	_____	_____
Signature	**Dated**	**Witness**	**Dated**

_____

Remarks