



INSURED'S STATEMENT DISABILITY CLAIM

To: The Insular Life Assurance Company, Ltd.

I hereby make claim under the policy/ies of this Company, numbered as follows: _____
All of the following answers and statements are true and complete, and correctly recorded.

I understand that the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

1. (a) Name	4. Give names of clinic, hospitals, sanitarium or other institutions where you received treatment and indicate dates of confinement. (a) _____ (b) _____ (c) _____
(b) Address	
(c) Contact No.	
(d) Date & Place of Birth	
(e) Occupation	
2. (a) Nature of Disability <input type="checkbox"/> Illness <input type="checkbox"/> Injury	5. Names of all physicians who have attended to you for your present illness/injury and indicate inclusive dates. (a) _____ (b) _____ (c) _____
(b) Date & Place of Commencement of Disability _____ _____	
(c) If through accident, was it reported to the Police or PC authorities? _____ If so, please attach Police or PC Investigation Report.	
3. (a) Give complete history of your illness or how injury was sustained. (Use reverse side if necessary). _____ _____ _____ _____	6. (a) Were you confined to bed at home? If so, indicate inclusive dates. _____
	(b) State briefly your present daily routine of life. _____ _____
	(c) Has there been any improvement in your condition? _____ If so, please describe. _____
(b) What was your work immediately prior to your becoming disabled?	7. Have you done any work since you gave up your usual occupation?
(c) When was the last date you were able to do this work?	8. When do you expect to return to work?
	9. If you were unable to perform your regular duties, could you do light clerical or shopwork, light housework, light outdoor work, chores etc.?
	10. Do you have any claim because of your illness or injury against any person or company? Give names and their addresses.

(Please use reverse side for additional information which would help us evaluate your claim)

Signed at _____ this _____ day of _____, 20____

WITNESS

ADDRESS OF WITNESS

INSURED

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20____, by the above claimant who exhibited to me his/her Residence Certificate No. A - _____, issued at _____ on _____.

NOTARY PUBLIC

INSURED'S AUTHORIZATION

I HEREBY AUTHORIZE any physician or other person or any hospital, sanitarium or institution to furnish THE INSULAR LIFE ASSURANCE COMPANY, LTD., any information that may be required concerning my illness or disability.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signed at _____ this _____ day of _____, 20____

WITNESS

INSURED