Tatil Life Assurance Limited
11 Maraval Road,
Box 1004, Port of Spain,
Republic of Trinidad and Tobago

CLAIMANT'S STATEMENT OF DISABILITY

Tatil

POLICY NUMBERS	POLICYOWNER	LIFE INSURED (if other than the policyowner)

1. EMPLOYMENT

(a) What was your occupation and nature of duties at start of disability?

(b) Name of employer and business address?

2. DISABILITY

(a) Date injury occured or sickness started

(b) Date you were forced to stop work

(c) Describle the cause of your diability

(d) Are you now totally disabled ☐ YES ☐ NO

(i) If no, when did you return to work?

(ii) If yes, when do you expect to return to work?

(e) What work have you done since the date your disability started?

3. MEDICAL TREATMENT

(Give names, addresses and dates of consultation)

(a) Physicians consulted since you became disabled

(b) Other physicians consulted during last 5 years

(c) Hospitals and institutions where you have been treated during last 5 years

4. ADDITIONAL INFORMATION AND REMARKS

PLEASE TURN OVER

5. LIST ALL OTHER POLICIES YOU HAVE WITH TATIL LIFE ASSURANCE LIMITED OR ANY OTHER COMPANY WHICH PROVIDES ACCIDENT, SICKNESS OR DISABILITY INSURANCE AND THE BENEFITS PROVIDED THEREUNDER.

NAME OF COMPANY	AMOUNT AND TYPE OF BENEFITS

6. **I declare** the above statements and answers to be full, complete and true. ☐

I hereby authorize any person who has employed me to give full details of my employment, including my salary and duties to Tatil Life Assurance Limited. ☐

7. **AUTHORIZATION:** I hereby authorize any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment, or any hospital or clinic where I have been a patient for such diagnosis, treatment, disease or ailment, to give full particulars , including any prior medical history, to Tatil Life Assurance Limited.
A photocopy of this authorization shall be as valid as the original.

Date

Signature of Insured

8. NOTE: IF THE POLICYOWNER IS NOT THE INSURED THE FOLLOWING DECLARATION MUST BE SIGNED

I declare the above statements and answers to be full, complete and true and I make claim for the benefits available under the policy.

Date

Signature of Policyowner

Address of Policyowner