



POLICY NUMBER: _____

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DISMEMBERMENT/LOSS OF USE - CONFIDENTIAL PHYSICIAN'S REPORT BLINDNESS

PERSONAL DETAILS									
INSURED	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 2px;">First Name</td> <td style="width: 50%; text-align: center; padding: 2px;">Middle Name</td> </tr> <tr> <td colspan="2" style="text-align: center; padding: 2px;">Last Name</td> </tr> </table>	First Name	Middle Name	Last Name					
First Name	Middle Name								
Last Name									
ADDRESS:									
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center; border-bottom: 1px solid black;">No.</td> <td style="width: 40%; text-align: center; border-bottom: 1px solid black;">street</td> <td style="width: 20%; text-align: center; border-bottom: 1px solid black;">city</td> <td style="width: 25%; text-align: center; border-bottom: 1px solid black;">country</td> </tr> </table>	No.	street	city	country				
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MAILING									
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PHONE NO: (____) _____									
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In order for a claim for blindness to be paid under this critical illness insurance policy, the following definition must be satisfied:

Loss of Use shall mean permanent, total and irrecoverable loss of use, beyond remedy by surgical or other means

With regards to hands and feet, loss shall mean dismemberment by severance at or above wrist or ankle joints respectively; with regard to sight, speech and hearing, total and irrecoverable loss

Permanent and uncorrectable loss of sight in both eyes, as confirmed by an ophthalmologist licensed and practicing in Trinidad and Tobago. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.

1. (a) When did your patient first consult you for any eye problem?

(b) How long has this person been your patient?

2. On what date did your patient first suffer symptoms or become aware of any eye problem? Please provide details.

3. (a) What is the correct vision or the field vision in each eye?

(b) On what date was this test performed?

(c) Please provide the name and address of the ophthalmologist.
