



POLICY NUMBER: _____

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

PERSONAL DETAILS

INSURED

First Name										Middle Name									
Last Name																			

ADDRESS:

No. street city country

MAILING **ADDRESS:**

No. street city country

PHONE NO: (____) _____ **DATE OF BIRTH:** ____/____/____

country code number month day year

In order for a claim for loss of hearing to be paid under this Loss of Use Benefit, 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 loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as confirmed by an otolaryngologist licenced and practicing in Trinidad and Tobago.

1. (a) When did your patient first consult you for hearing or related problems?

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

2. On what date did your patient first suffer symptoms or become aware of hearing loss? Please provide details.

3. (a) What is the auditory threshold in each ear?

(b) Please give the date of the first audiogram that established this.

Please provide a copy of the audiogram if available.

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