



POLICY NUMBER: _____

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ACCIDENTAL LOSS/DISEMBLEMENT - CONFIDENTIAL PHYSICIAN'S REPORT
MAJOR DISEMBLEMENT

PERSONAL DETAILS			
INSURED	<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width:50%; text-align:center;">First Name</td> <td style="width:50%; text-align:center;">Middle Name</td> </tr> </table>	First Name	Middle Name
	First Name	Middle Name	
<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width:100%; text-align:center;">Last Name</td> </tr> </table>	Last Name		
Last Name			
ADDRESS:			
No.	street	city	country
MAILING			
No.	street	city	country
PHONE NO: ()		DATE OF BIRTH: / /	
country code	number	month	day / year

In order for a claim for major burns 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

1. On what date were you first consulted for the accident /loss of use and, at that time, how long has impairment been present?

2. (a) Has your patient previously suffered from the condition specified above or any related medical condition? Yes No
- (b) If yes, please state the dates and situations resulting in medical condition

3. Please describe the circumstances leading to the occurrence of the accidental dismemberment/loss of use?

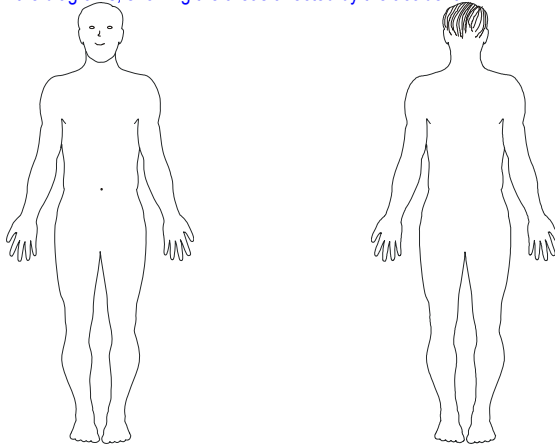
4. What was the exact date of the incident resulting in accidental dismemberment/loss of use?

5. Please describe the extent of your patient's condition as follows:-
 - (a) the percentage of the damage done to limbs or sensory glands.

 - (b) Which area of the body is majorly affected by the accidental occurrence (limbs, torso, etc)?

 - (c) the nature of the accidental dismemberment/loss of use?

6. Please shade in the diagrams, showing the areas affected by the accident



7. Please give details of any tests performed.

8. Please provide details of any surgery performed, including date, hospital, name of surgeon and site of graft.

9. Is there anything in your patient's habits or personal history which would have increased the risk of accident or burns?

10. Are you aware of any liability claim involving a third party?

11. Please give the names and addresses of other physicians consulted by your patient for this condition.

12. Please provide details of your patient's tobacco use including amount per day and date last used.

Please provide copies of any specialist or hospital reports for our Consultant's review, dated within the last six (6) months. .

Our contract requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient: Yes No

Signature: _____

Dated: _____

Name (in block capitals please): _____