



POLICY NUMBER: _____

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**CLAIM FORM – DISMEMBERMENT OR LOSS OF USE PHYSICIAN’S STATEMENT
PARALYSIS**

PERSONAL DETAILS			
INSURED	<input type="text"/>	<input type="text"/>	
	First Name	Middle Name	
	<input type="text"/>	<input type="text"/>	
	Last Name		
ADDRESS:			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
No.	street	city	country
MAILING			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
No.	street	city	country
PHONE NO: (<input type="text"/>) <input type="text"/>		DATE OF BIRTH: <input type="text"/> / <input type="text"/> / <input type="text"/>	
country code	number	month	day / year

In order for a claim for paralysis to be paid under the Loss of Use benefit, the following definition must be satisfied:

Complete and permanent loss of the use of two or more limbs through paralysis, for a continuous period of 180 days, confirmed by a physician licensed and practicing in Trinidad and Tobago.

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

1. Please provide a brief outline of the medical history leading to your patient's paralysis.

2. When did your patient first consult you for this condition?

3. If paralysis was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition?

4. Please describe the following:

 - Which limbs are affected?

 - Details of exact loss of function

 - Residual use, if any, of his/her affected limbs.

 - The underlying cause of the condition.
