COLONIAL LIFE INSURANCE COMPANY (TRINIDAD) LIMITED

POLICY NUMBER: _____

HEAD OFFICE: 29 St. Vincent Street, Port Of Spain, Republic of Trinidad and Tobago, W.I., Tel: (868) 623-1421, Fax: (868) 627-3821, Email: info@clico.com, Website:clico.com

CLAIM FORM – DISMEMBERMENT OR LOSS OF USE

PROOF OF CLAIM - CLAIMANT'S STATEMENT

1. 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

2. CLAIM AND RELATED DETAILS

(a) Is your medical condition related to any of the following:

I. Employment Yes ☐ No ☐

II. Automobile Accident Yes ☐ No ☐

III. Other Accident Yes ☐ No ☐

IV. Illness Yes ☐ No ☐

(b) If due to Employment please describe the nature and extent of your medical condition? _____

_____

_____

(c) State the duties (personal and occupational that you are unable to perform? _____

_____

_____

(d) On what date did you stop performing these duties _____

(e) If due Automobile or Other Accident please describe the nature and extent of your medical condition? _____

_____

_____

On what date did your accident/medical condition diagnosed and/or surgery performed? _____

(f) If due to Illness on what date did symptoms first commence? _____

Please describe the symptoms _____

_____

_____

(g) On what date did you first consult a medical practitioner in connection with your illness? _____

Please indicate the name and address of the Physician seen:

Name: _____

Address: _____ PHONE NO: (_____)_____
country code number

(h) Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates. Yes ☐ No ☐

_____

(i) Have you previously suffered from, or received treatment for, a similar or related condition? If yes, please give details including dates. Yes ☐ No ☐

_____

_____

3. MEDICAL CONSULTATIONS

(a) Please provide the name and Address of your personal physician.

_____

_____