



POLICY NUMBER: _____

HEAD OFFICE: 29 St. Vincent Street, Port Of Spain, Republic of Trinidad and Tobago, W.I., Tel: (868) 623-1421, Fax: (868) 627-3521, Email: info@clico.com, Website:clico.com

CLAIM FORM – DISMEMBERMENT OR LOSS OF USE PROOF OF CLAIM – EMPLOYER'S STATEMENT

1. PERSONAL DETAILS

INSURED

EMPLOYER'S NAME

EMPLOYER'S NAME

ADDRESS: _____
No. street city country

MAILING ADDRESS: _____
No. street city country

PHONE NO: (____) _____
country code number

2 (a) Name of Employee in full: _____ (b) Insurance Amount: _____

3 (a) What is the employee's current occupation? _____

(b) Provide a description of the employee's current occupation _____

4 How is the employee's salary Rated?

I. Weekly

II. Fortnightly.....

III. Monthly

5 (a) Date of .Accident/Disability/Dismemberment _____ (b) Date last actively at work: _____

(c) Date of expected return: _____ (d) What is the employee current occupation? _____

6 (a) Is the employee's current medical conditions as result of occupation: Yes No

(b) If Yes please indicate if the Employee can perform his job function to full capacity upon resumption of work. Yes No

7 (a) Has he employee been deemed medically unfit for perform is current job?(Please provide medical certificate if YES) Yes No

(b) Date of Termination: _____

8

Date:

Signature of Employer's Authorized Representative

Title