COLINA

Colina Insurance Limited
P.O. Box N4728
Nassau, Bahamas

# CLAIMANT'S STATEMENT

## SECTION A: Insured Person's Information

Full Legal Name

| Last Name | First Name | Middle Name | Maiden Name |
|---|---|---|---|
| | | | |

Date of Birth (Day / Month / Year)

Sex ☐ Male ☐ Female

National Insurance Number

Residential Address

| No. and Street | City | State/Province/Island/Country | P.O. Box |
|---|---|---|---|
| | | | |

Loan Type
☐ Residential Mortgage ☐ Commercial Mortgage ☐ Credit Card ☐ Line of Credit
☐ Consumer Loan ☐ Term Loan ☐ Overdraft

Loan No.

Currency ☐ BSD ☐ USD

Branch No. | Branch Location | Country

Date of Loan (Day / Month / Year) | Loan Amount at Application Date | Indebtedness at Date of Insured Event

Claim type
☐ Life ☐ Critical Illness ☐ Accidental Dismemberment

Date of insured event (Day / Month / Year)

Were loan payments in arrears at any point during the loan for more than 90 days? ☐ Yes ☐ No If 'Yes,' when?

## SECTION B: Bank Representative's Information

Bank Representative

| Print Name | Signature | Day / Month / Year |
|---|---|---|
| | | |

Title | Branch Location | Telephone

Email Address

**The following additional documents are required to accompany this form:**

**Death Claims:**

1. A copy of the Insurance Application Form or Insurance Enrolment Form
2. Proof of Insured Person's Identity (Passport, Voter's Card, or Driver's License ***plus*** Birth Certificate)
3. A copy of the loan agreement
4. A copy of the loan history from the Insurance Effective Date to the Date of the Insured Event
5. A certified copy of the Death Certificate
6. The Attending Physician's Statement, completed by the physician who attended the deceased

**Critical Illness/Accidental Dismemberment:**

1. A copy of the Insurance Application Form or Insurance Enrolment Form
2. Proof of Insured Person's Identity (Passport, Voter's Card, or Driver's License ***plus*** Birth Certificate)
3. A copy of the loan agreement
4. A copy of the loan history from the Insurance Effective Date to the Date of the Insured Event
5. Insured's Statement of Claim (completed by Insured Person)
6. The Attending Physician's Statement, completed by the Insured Person's Attending Physician

## SECTION C: Authorization to Release Information

I, hereby, authorize any hospital, physician or other person who examined or attended _____ to furnish to COLINA INSURANCE LIMITED, its reinsurers or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital and medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Authorized Representative of the Insured Person

| Print Name | Signature |
|---|---|
| | |

Relationship to Insured Person

Day / Month / Year

COLINA

Colina Insurance Limited
P.O. Box N4728
Nassau, Bahamas

# ATTENDING PHYSICIAN'S STATEMENT (PROOF OF CLAIM)

**This form is to be furnished without expense to Colina Insurance Limited.**

## SECTION A: Insured Person's Information

Full Legal Name

| Last Name | First Name | Middle Name | Maiden Name |
|---|---|---|---|
| | | | |

Sex
☐ Male
☐ Female

Date of Birth
Day Month Year

Last Known Residence

| No. and Street | City | State/Province/Island/Country | P.O. Box |
|---|---|---|---|
| | | | |

Disease or condition directly leading to Insured Event (Disease, injury or complication)

Date of Diagnosis
Day Month Year

Date Insured Person informed of this illness
Day Month Year

Antecedent causes (morbid conditions, if any, giving rise to the above conditions) due to or as a consequence of the Insured Event

Date of Diagnosis
Day Month Year

Date Insured Person informed of this illness
Day Month Year

Interval between onset and Insured Event

Other significant conditions:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cardio-vascular Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No |
| Gastro-intestinal Disease | ☐ Yes | ☐ No | Endocrine Disorder | ☐ Yes | ☐ No | Neurological Disorder | ☐ Yes | ☐ No |
| Musculo-skeletal Disease | ☐ Yes | ☐ No | Lung Disease | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No |
| Liver Disease | ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No | Other | ☐ Yes | ☐ No |
| Renal Disease | ☐ Yes | ☐ No | Immunological Disease | ☐ Yes | ☐ No | | | |

If "Yes", state medical condition:

Did the Insured Person have an abnormal EKG's or Laboratory Test (including AIDS Antibody)? ☐ Yes ☐ No

Was Insured Event related to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

Date of Diagnosis
Day Month Year

Did the Insured Person receive treatment during the last five (5) years from any other physician? ☐ Yes ☐ No

If yes, please indicate the name(s) of other physician(s) consulted, along with date(s) of and the reason(s) for consultation.

## SECTION B: Attending Physician's Information

Attending Physician

| Print Name | Signature | Day Month Year |
|---|---|---|
| | | |

Address

| No. and Street | City | State/Province/Island/Country | P.O. Box |
|---|---|---|---|
| | | | |

Email Address

Telephone Numbers

| Business | Fax | Other |
|---|---|---|
| | | |

**Please stamp below for certification.**

Physician's Stamp

**Return to:**

Colina Insurance Limited
Life Claims Unit
308 East Bay Street
P. O. Box N-4728
Nassau, Bahamas

**Or by email to:**
cibcclaims@colina.com