COLINA

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

# INSURED'S STATEMENT
# CRITICAL ILLNESS

## 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

Residential Address

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

Email Address

Telephone Numbers

| Residence | Business | Cell | Fax |
|---|---|---|---|
| | | | |

What was your occupation at the onset of your illness?

Please describe your regular duties.

Please provide the details and nature of your illness.

When did you first consult a doctor for your illness?

Please give details of the treatment you have received, including details and dates of any hospitalizations:

Please give the name, address and telephone number of all physicians who have treated you, and all hospitals and other medical facilities at which you have been treated:

Have you suffered from or received treatment for a similar illness? ☐ Yes ☐ No If Yes, give full details and dates.

## SECTION B: Declaration and Authorization by Insured Person

1. I, hereby, authorize any physician or other health care professional, any hospital, clinic or other medical or paramedical organization, to furnish to Colina Insurance Limited, or a representative thereof, any and all information with respect to any illness medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records.
2. I declare that the contents of this form have been explained and are fully understood.
3. I understand that completion of this form does not constitute approval of the claim by Colina Insurance Limited.
4. I declare that the information provided herein is true and accurate.
5. A photographic copy of this form and the associated authorization shall be as valid as the original.

Insured Person

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

Bank Representative / Witness

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

COLINA

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

# INSURED'S STATEMENT
# ACCIDENTAL DISMEMBERMENT

## 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

Residential Address

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

Email Address

Telephone Numbers

| Residence | Business | Cell | Fax |
|---|---|---|---|
| | | | |

What was your occupation at the date of your accident?

Please describe your regular duties:

Date of the accident

Day Month Year

Place of the accident (at home, at work or other)

Describe fully how the accident occurred.

When did you first consult a doctor?

Please give specific details of the treatment you have received.

Please give the name, address and telephone number of the attending physician(s) who treated you and the hospital or any other medical facility at which you were treated.

## SECTION B: Declaration and Authorization by Insured Person

1. I, hereby, authorize any physician or other health care professional, any hospital, clinic or other medical or paramedical organization, to furnish to Colina Insurance Limited, or a representative thereof, any and all information with respect to any illness medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records.
2. I declare that the contents of this form have been explained and are fully understood.
3. I understand that completion of this form does not constitute approval of the claim by Colina Insurance Limited.
4. I declare that the information provided herein is true and accurate.
5. A photographic copy of this form and the associated authorization shall be as valid as the original.

Insured Person

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

Bank Representative / Witness

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