PAN AMERICAN LIFE
INSURANCE OF TRINIDAD AND TOBAGO
A member of the Pan-American Life Insurance Group

CLAIMANT'S STATEMENT FOR ACCIDENT & SICKNESS BENEFITS

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

PART A - COMPLETE IN FULL

1. Full Name (Please Print)

2. Policy Number

3. Age

4. Height

5. Weight

6. Residential Address

ID# _____ Tel# _____

7. Business Address
No. Street
City_____Country
Employer
Nature of Business _____

8a. Occupation

8b. Average Earnings per Week

8c. Describe Duties

9. Give date and hour when accident (or beginning of illness if disability Claim) occurred?
Day Month Year
_____ _____ _____
at o'clock M.

10. On what date did you stop performing all your occupational duties?
Day Month Year
_____ _____ _____

11. Have you done any work since commencement of disability?
If yes, explain

12. How do you spend your time?

13. Confined to house from _____
to

14. Confined to hospital from _____
to _____

15. When do you expect to return to work?
Day Month Year
_____ _____ _____

16 Bank_____ Branch _____

Account #_____ Email Address _____

17. Give date consulted and Name and Address of every Physician consulted by you on account of present condition

Day	Month	Year	Name	Address

18. What other Life, Health or Accident Insurance providing for disability benefits have you?

Name of Company	Address	Amount of Weekly Indemnity

PART B - COMPLETE FOR ACCIDENT CLAIM ONLY

A. What bodily injuries did you sustain wholly by the Accident?

B. Where and how did the Accident occur?

C. If partial disability is claimed state the particular duties you were unable to perform during the entire period of partial disability?

D. Were you on vacation or unemployed during any period of disability?

E. Has disability resulting from Accident ended and is this your full claim?

F. How long were you totally disabled_____(weeks)_____(days)

G. How long were you partially disabled_____(weeks)_____(days)

PART C - COMPLETE FOR SICKNESS CLAIM ONLY

A. Describe fully your present conditions

B. Has any member of your family been afflicted with a similar disease?

C. Have you seen a Physician within the last three years for reasons other than your present condition. If yes give reasons, date, name & address.

NOTE: This Blank form is furnished to the Insured without prejudice to or waiver of any right of defense that the Company may have relative to any claim filed hereunder

NB.

All expenses must be supported by detailed bills. Only original bills are acceptable. Hospital Bills should state the number of days spent and the charge for each day as well as itemized charges for other hospital services; drug bills should show the date of purchase, prescription number, name of patient, name of doctor, name or type of drugs and cost. Bills for x-rays should show the date, patient's name, and the charges.

The foregoing statements are full and true to the best of my knowledge and belief, and I agree that payment according to the terms of the policy, for the period of disability as herein indicated, should be in full satisfaction and discharge of any and all claims, the cause of which originated prior to the date hereof.

I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person that has any records or knowledge of my family or me, to give to **Pan-American International Insurance Corporation- Barbados** any and all information about my family members or me with reference to our finances, our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I also authorize **Pan-American International Insurance Corporation- Barbados** to provide the information derived from this application and any other existing record, to service providers and related third parties in order to evaluate any insurance proposal request made by me and for the purposes of administration of this policy.

A photographic copy of this authorization shall be as valid as the original.

_____
(witness)

Signed _____

Date_____ _____ _____
Day Month Year

ATTENDING PHYSICIAN'S STATEMENT
-ACCIDENT AND SICKNESS-
THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Patient's name	Age

1. Nature of sickness or injury.
(Describe complications if any)

2.	Is condition due to pregnancy?	Yes ☐ No ☐
3.	If "yes" what was approximate date of commencement of pregnancy?	Date _____ _____
4.	If fracture or dislocation, state whether complete or incomplete.	☐ Complete ☐ Incomplete
5.	If fracture of long bones, state whether fracture is through shaft or extremity.	☐ Shaft ☐ Extremity
6.	Was it confirmed by X-ray?	Yes ☐ No ☐
7.	When did symptoms first appear or accident happen?	Date _____ _____
8.	When did patient first consult you for this condition?	Date _____ _____
9.	Has patient ever had same or similar condition? (If "yes" state when and describe)	Yes ☐ No ☐

10. Describe any other disease or family infirmity affecting present condition.

11. *Nature of surgical or obstetrical procedure, if any
(Describe fully)

12.	Give dates of treatment.	Charge per call Office _____ $ _____ Home _____ $ _____ Hospital _____ $ _____
13.	Is patient still under your care for this condition? If discharged, give date.	Yes ☐ No ☐ Date discharged _____ _____
14.	If patient hospitalized, give name and address of hospital.	_____ Hospital _____ _____ City State _____ _____ Date Admitted Date Discharged
15.	How long was patient totally disabled (unable to work)?	From _____ through _____
16.	If sickness, was patient confined to the house? (If "yes" give dates).	Yes ☐ No ☐ From _____ through _____
17.	Is condition due to injury or sickness arising out of patient's employment? (If "yes" explain).	Yes ☐ No ☐

REMARKS:

I HEREBY CERTIFY THAT MY ANSWERS TO THE FOREGOING QUESTIONS ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date _____ _____ SIGNATURE _____
Physician or Surgeon

_____
(Print or type name)

_____
Office Address

Pan-American International Insurance Corporation- Barbados
P.O. Box 197 Cheapside Bridgetown, Barbados | Tel: 246.537.1200 Fax: 246.427.6596 | palig.com