ADAMJEE LIFE ASSURANCE COMPANY LIMITED

CLAIMANT STATEMENT (DISABILITY)

Group Policy No. _____

Claim No._____

1. Name of the Employee (In Block Letters)		
2. Sex		
3. Age		
4. Occupation		
5. Duties		
6. (a) Date of Accident (b) Time of Accident (A.M./P.M.) (c) Place of Accident		
7. Describe accident in detail		
8. Describe injuries		
9. Give name & Address of the Physician/ Surgeon who first attended you		
10. If hospitalized, give name and address of hospital		
11. Total and absolutely disabled	From:	To:
12. Partially disabled	From:	To:
13. Confined to Hospital	From:	To:
14. Are you making any other insurance or compensation claim as a result of this accident? (if yes kindly give details)		

I, the above claimant, being duly sworn, depose and say that the foregoing statements are full and true to the best of my knowledge and belief, and agree that payment according to the terms of the policy, claims, the cause of which originated prior to date hereof.

Signed_____

Date _____

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the Company, or its authorized representative, any and all information with respect to any injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

Signature of the Claimant_____