Sagicor

HEAD OFFICE, KINGSTON JAMAICA
CLAIMANT'S STATEMENT – DISMEMBERMENT BENEFIT

1. (a) Name of Claimant in full (b) Usual residence of Claimant (c) Duration of residence in such country	(a) …….. (b) City or Town of …… Parish of …….. (c) Country …….....Duration ……years
2. (a) Date of Birth (b) Occupation at time of accident	(a)……..... (b)…….....
3. (a) Date and time of accident (b) Where did the accident occur (c) Give a brief description of the accident (d) Were you injured in the course of any employment? (e) Give name of hospital where you were confined. (f) Dates of hospital confinement (g) Physician's name and address	(a) Date……Time……. (b) …….. (c) …….. …….. …….. …….. (d) …….. (e) …….. (f) …….. (g) Name…….. Address…….. First treated……..where……
4. Policies under which you are claiming 5. Are you legally entitled to receive the benefits provided under the terms and provision of the Contract? 6. If an optional settlement is available and you do not desire payment in one sum, state type of settlement desired.	Policy Number Amount …….. …….. …….. …….. ……..

I hereby certify that the above answers are full and true to the best of my knowledge and belief.

I hereby authorize and direct every person or institution of any nature whatsoever and without limiting the generality of the foregoing, any physician, hospital or government agency, to disclose fully to Sagicor Life Jamaica Limited or it duly authorized representative, all the following information in their possession or within their knowledge respecting……. .....Claimant or respecting his health and medical history, and to honour a photographic copy of this authorization; and this shall constitute full and sufficient authority for so doing.

Dated at……...this…….day of…….20…….

……. (Witness)

……. (Signature of Claimant)

……... (Address)

If space provided above is inadequate for complete answers, please give additional particulars on the back of this form.

Sagicor

28-48 Barbados Avenue, Kingston 5, • P.O., Box 439, Kingston, Jamaica • Phone: (876) 929-8920-9, Cable 'SAGICOR' Fax: (876) 929-4730.

PHYSICIAN'S STATEMENT – DISMEMBERMENT BENEFIT

1. Name and Address of Patient	Name…… Address……. ……..
2. (a) Date of first attendance for present injury (b) Date of most recent treatment	(a)……20……. (b)……20…….
3. Describe briefly details of accident	…….. …….. …….. ……...
4. (a) If the accident caused the loss of hand or foot, please indicate member lost and level of amputation (b) Date of amputation	(a)…… …… …… (b)……..20…….
5. (a) If the accident caused total and irrecoverable loss of sight, give date on which loss occurred (b) If the injury necessitated removal of eye, give date of removal (c) What was the vision in each eye prior to the accident (d) What percentage of vision if any now remain in the injured eye	(a)…….20…….. (b)……20…….. (c)……..... ……... (d)……..
6. (a) Was the injury described solely responsible for the loss (b) If not, give particulars of any contributing cause or Causes	(a)…….. (b)……... …… …… ……

Date……..20……Signed……..
Attending Medical Physician

Office Address…….
……
……...