CLAIM FORM

THIS SECTION TO BE COMPLETED BY THE PERSON CLAMING

Full Name:(Mr/Mrs/Ms)

Residential Address:

Date of Birth: (DD / MM / YY) TRN:

Tel: Other:

DETAILS OF DISABILITY

1. What do you understand to be wrong with you?

2. State the nature and the date of earliest symptoms of this disability.

3. When did you first consult a medical practitioner in connection with your current disability? (DD / MM / YY)

4. Kindly provide names, addresses and telephone numbers of all medical practitioners *(including specialists etc.)* consulted in connection with this disability.

5. Name and address of your usual family doctor.

DECLARATION

I hereby authorize any medical practitioner, hospital or any other person to furnish the **INSURER** or its appointed representative, with any information relating to my illness or injury. I do hereby declare and warrant that the answers given by me in this report are in every respect factual, true and correct and that no material information has been withheld nor has any relevant information regarding the circumstances have been omitted.

Name:

Signature: Date:(DD / MM / YY)

Witness Name:

Signature: Date:(DD / MM / YY)

THIS SECTION TO BE COMPLETED BY MEDICAL ATTENDANT

We require an objective medical opinion of the impairment experienced by your patient. Provide full details of all limitations in movement, use or restriction.

The details of all treatment from the elementary to the most advanced will provide us with a full picture of the condition and its progression.

Thank you for your assistance in this claim, kindly provide us with the following information.

1. Diagnosis of patient's condition:

2. The cause of the patient's disability:

3. Date the patient was informed of the diagnosis? (DD / MM / YY)

4. When did the patient experience the earliest symptoms hereof? (DD / MM / YY)

5. Details of complications or concurrent conditions:

a. Date of first consultation and treatment with regards to the patient's present medical condition (DD / MM / YY)

b. Date of last consultation and treatment with regards to the patient's present medical condition (DD / MM / YY)

6. Names, addresses and contact numbers of any other medical practitioners who may be or have been consulted:

8. Please provide details of other information, which may be useful to the company in assessing the customer's right to compensation for this disability:

7. Full details of treatment from the date of first consultation to the current date, the results and the reasons, if any, for change

9. Please provide us with copies of all investigations: • Laboratory tests • Specialist Reports • Additional documents, please state:

I/We declare that all the aforegoing statements are true and correct.

Medical Qualification: **Practice #:**

Certified Stamp: **Date:(DD / MM / YY)**

See overleaf for claim submission requirements.

What you are required to do in order to make a claim

You are required to notify us of your disability within a maximum of thirty **(30) days** from the day you become disabled. All documentation required must be submitted within **(90) days** from the day you become disabled.

Documents required:

- ***Completed claim form***
- ***Claim form completed by medical practitioner***
- ***Copy of your Identification and TRN***
- ***Last 3 Bill Express Transaction receipts***

The insurer reserves the right to request any additional information required to validate a claim.

Documents are to be submitted via:

- ***Fax Number: 968-1920, or***
- ***Email: insureit@gkco.com, or***
- ***PO Box 524,***
  Kingston 5,
  Jamaica W.I.