



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

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| 1. FULL NAME (Please Print) <hr/> | 9. Give date and hour when accident (or beginning of illness if disability Claim) occurred? Day _____ Month _____ Year _____ _____ at _____ o'clock _____ M. |
| 2. POLICY NUMBER <hr/> | 3. AGE <hr/> |
| 4. HEIGHT <hr/> | 5. WEIGHT <hr/> |
| 6. RESIDENCE ADDRESS <hr/> ID# _____ Tel# _____ | 10. On what date did you stop performing all your occupational duties? Day _____ Month _____ Year _____ |
| 7. BUSINESS ADDRESS No. _____ Street _____ City _____ Country _____ EMPLOYER _____ NATURE OF BUSINESS _____ | 11. Have you done any work since commencement of disability? If yes, explain _____ |
| 8a. OCCUPATION _____ 8b. Average earnings per week _____ | 12. How do you spend your time? <hr/> |
| 8c. DESCRIBE DUTIES <hr/> | 13. Confined to house from _____ to _____ |
| 16. BANK _____ BRANCH _____ ACCOUNT # _____ EMAIL ADDRESS _____ | 14. Confined to hospital from _____ to _____ |
| 17. Give date consulted and Name and Address of every Physician consulted by you on account of present condition Day _____ Month _____ Year _____ Name _____ Address _____ <hr/> <hr/> | 15. When do you expect to return to work? Day _____ Month _____ Year _____ |
| 18. What other Life, Health or Accident Insurance providing for disability benefits have you? Name of Company _____ Address _____ Amount of Weekly Indemnity _____ <hr/> <hr/> | |

PART B - COMPLETE FOR ACCIDENT CLAIM ONLY

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| A. What bodily injuries did you sustain wholly by the Accident? <hr/> |
| B. Where and how did the Accident occur? <hr/> |
| C. If partial disability is claimed state the particular duties you were unable to perform during the entire period of partial disability? <hr/> |
| D. Were you on vacation or unemployed during any period of disability? <hr/> |
| E. Has disability resulting from Accident ended and is this your full claim? <hr/> |
| 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

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| A. Describe fully your present conditions <hr/> |
| B. Has any member of your family been afflicted with a similar disease? <hr/> |
| 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. <hr/> |
| 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 me or my family, to give to American Life and General Insurance Company (Trinidad & Tobago) Limited any and all information about me or my family members with reference to health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original.

_____ SIGNED _____
 (WITNESS)

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

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|--|---|--|-----------------|--------------|----------|------------|----------|----------------|----------|
| Patients name _____ | Age _____ | | | | | | | | |
| 1. Nature of sickness or injury. (Describe complications if any) | | | | | | | | | |
| 2. Is condition due to pregnancy? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| 3. If "yes" what was approximate date of commencement of pregnancy? | Date _____ | | | | | | | | |
| 4. If fracture or dislocation, state whether complete or incomplete. | <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete | | | | | | | | |
| 5. If fracture of long bones, state whether fracture is through shaft or extremity. | <input type="checkbox"/> Shaft <input type="checkbox"/> Extremity | | | | | | | | |
| 6. Was it confirmed by X-ray? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| 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 <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| 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. | <table style="width:100%; border: none;"> <tr> <td></td> <td align="right">Charge per call</td> </tr> <tr> <td>Office _____</td> <td align="right">\$ _____</td> </tr> <tr> <td>Home _____</td> <td align="right">\$ _____</td> </tr> <tr> <td>Hospital _____</td> <td align="right">\$ _____</td> </tr> </table> | | Charge per call | Office _____ | \$ _____ | Home _____ | \$ _____ | Hospital _____ | \$ _____ |
| | Charge per call | | | | | | | | |
| Office _____ | \$ _____ | | | | | | | | |
| Home _____ | \$ _____ | | | | | | | | |
| Hospital _____ | \$ _____ | | | | | | | | |
| 13. Is patient still under your care for this condition? If discharged, give date. | Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> From _____ through _____ | | | | | | | | |
| 17. Is condition due to injury or sickness arising out of patient's employment? (If "yes" explain). | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |

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