RESOLUTION LIFE
ASSURANCE COMPANY LTD

CLAIMANT'S STATEMENT FOR TOTAL DISABILITY BENEFITS

Policy #					
Name	LAST NAME	FIRST NAME	MIDDLE NAME		
Gender	Male ☐ Female ☐	**Marital Status**	Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐		
Date of Birth	(DD/MM/YYYY)		**Nationality**		
National Registration #		**Passport Number**		**Driver's Licence Number**	
Residence Address					
Telephone Contact	HOME	BUSINESS	CELL		
Permanent Address (if different from residence address)					
Email Contact					

1. What was your occupation before disability?

2. Describe fully your present condition, what parts of the body are affected and how?

3. (a) Does your disability completely prevent you from engaging in any other business or occupation whatsoever for remuneration or profit?

YES ☐ NO ☐

4. (a) Are you wholly confined to bed, house or institution?

YES ☐ NO ☐

If yes, state which

(b) If no, describe your daily activities

(c) When did disability occur?

(d) Has there been any improvement in your condition?

YES ☐ NO ☐

If yes, describe

(c) If yes, when do you expect to be able to start work even in a limited way?

(d) If no, on what date were you able to do any type of work?

(e) What is the nature of the work?

(f) Is it full or part time?

(g) Who is your employer?

(h) What is your monthly salary?

5. Are you receiving benefits from any other insurance company, pension plan, salary continuance plan, government plan including workmen's compensation, N.I.S., etc.

YES ☐ NO ☐

If yes, state amount received each month, source and date benefit commenced.

6. **I HAVE SEEN THE FOLLOWING DOCTORS**	**ADDRESS**	**ACTUAL DATE CONSULTED DURING PAST SIX MONTHS**

I certify that the above answers are full and true and authorise RESOLUTION LIFE ASSURANCE COMPANY LTD. to obtain information relative to my Medical History from doctors consulted.

DATED AT_____ **SIGNATURE OF INSURED**_____

THIS _____ **DAY OF** _____ _____
DAY MONTH YEAR