INCOME PROTECTION CLAIM FORM

CLAIM NO._____

CLIENT NO._____

POLICY NO.		DATE OF EXPIRY
LIFE INSURED		
POLICY OWNER (IF DIFFERENT FROM LIFE INSURED)		
ADDRESS:		

A: SECTION TO BE COMPLETED FOR ACCIDENT CLAIMS ONLY

1. DATE AND TIME OF ACCIDENT	1 ...../...../..... AT.....AM/PM
2. WHERE DID THE ACCIDENT HAPPEN	2.
3. HOW DID THE ACCIDENT HAPPEN	3.
4. WHAT INJURIES WERE SUSTAINED	4.

B. SECTION TO BE COMPLETED FOR SICKNESS CLAIMS ONLY

1. WHAT IS THE NATURE OF THE SICKNESS	1.
2. WHEN DID IT FIRST BECOME APPARENT	2 ...../...../19.....
3. HAVE YOU SUFFERED FROM THIS CONDITION BEFORE: IF SO FOR HOW LONG	3.

C. SECTION TO BE COMPLETED FOR ALL CLAIMS

1.(A) OCCUPATION AT TIME OF DISABLEMENT	(A)
(B) SELF-EMPLOYED OR EMPLOYEE	(B)
(C) AVERAGE WEEKLY EARNINGS	(C)

2. (A)NAME OF DOCTOR FIRST CONSULTED	(A)
(B) DATE OF FIRST CONSULTATION	(B) ...../...../19.....

3. CAN COMPENSATION BE CLAIMED: (A) FROM ANY OTHER SOURCE	(A) YES NO
(B) FROM WORKERS COMPENSATION	(B) YES NO
IF YES TO EITHER (A) OR (B) STATE: (C) NAME OF ORGANISATION	(C)
(D) AMOUNT OF WEEKLY COMPENSATION	(C)

4. HAS THE ACCIDENT OR SICKNESS BEEN THE CAUSE OF: (A) TOTAL DISABLEMENT FROM WORKING	(A) YES/NO.....FROM...../...../..... TO...../...../.....
(B) PARTIAL DISABLEMENT FROM WORKING	(B) YES/NO....FROM...../...../..... TO...../...../.....

5. IF STILL DISABLED, STATE WHETHER TOTAL OR PARTIAL	TOTAL/PARTIAL

I HEREBY DECLARE AND WARRANT THAT THE ANSWERS WRITTEN AGAINST THE ABOVE QUESTIONS ARE TRUE, AND THAT I WILL ANSWER TO THE BEST OF MY KNOWLEDGE AND BELIEF ANY OTHER QUESTIONS RELATING TO THE ABOVE WHICH THE COMPANY MAY REQUIRE, AND DECLARE THAT THE CONDITIONS OF MY INSURANCE HAVE BEEN FULLY COMPILED WITH. AND I AGREE THAT IF I HAVE MADE, OR IN ANY FURTHER DECLARATION THE COMPANY MAY REQUIRE OF ME IN RESPECT OF THE SAID ACCIDENT SHALL MAKE, ANY FALSE OR UNTRUE STATEMENT, SUPPRESSION, OR CONCEALMENT, THE POLICY SHALL BE VOID, AND MY RIGHT TO COMPENSATION ABSOLUTELY FORFEITED. AND I AM WILLING, IF REQUIRED, TO MAKE A SOLEMN DECLARATION BEFORE A COMMISSIONER OF OATHS OF THE TRUTH OF THE WHOLE FOREGOING STATEMENT, OR OF ANY OTHER STATEMENTS I MAY MAKE IN CONNECTION WITH THE CLAIM.

Signature of Claimant.....Date...../...../.....

CERTIFICATE OF MEDICAL ATTENDANT

Patients Name (In Full):

1. Nature and extent of injuries or sickness	1.
2. Date of first consultation (a) Date of any subsequent consultation	2. ...../...../..... (a)
3. Has there been any previous treatment for this or allied conditions (a) Is there any condition (past or present) affecting the present disability. If so to what extent.	3. (a)
4. How long was, or will the patient be:- (a) Totally disabled from working (b) partially disables from working (partial is applicable to accidents only	(a) From...../...../..... to ...../...../..... (b) From ...../...../..... to ...../...../.....
TOTALLY DISABLED means when the claimant is absolutely incapacitated from attending to any portion of his business or occupation. **PARTIALLY DISABLED** means when the Claimant is only able to attend to some portion of his business or occupation.	

Signature of Medical Attendant.....Date...../...../.....