DISABILITY CLAIM FORM - GROUP LIFE & INDIVIDUAL LIFE

CLAIM FORM : ☐ **GROUP LIFE** ☐ **INDIVIDUAL LIFE**

Form Completion Instruction:

1) This form may be completed by those having a claim for disability benefits as a person nominated by the Policy Holder, Guardian, Assignee, Trustee or a successor
2) Please fill the form with single pen without omissions / deletions
3) Please complete the form with legible handwriting, incomplete form may cause delay in processing of disability claim benefits

CHECKLIST OF DOCUMENTS REQUIRED (Any other requirement(s) may be requested on claim where deem necessary):

1. Treatment Records (Original) ☐
2. Hospital Discharge Certificate ☐
3. Copy of CNIC - Claimant ☐
4. Copy of Passport (If Living Abroad) ☐
5. Attendance Record ☐
6. Salary Record - Last Drawn ☐

CLAIM FORM A: INFORMATION ABOUT CLAMAINT / POLICY HOLDER

(To be completed by the clamaint)

Name of Company / Claimant: _____

CNIC : _____ Marital Status : _____

Gender : _____ Contact No. : _____

D.O.B : _____ Policy No. : _____

Claiming as: ☐ Self ☐ Nominee ☐ Beneficiary ☐ Guardian

EVENT DETAILS

Type of Disability: ☐ Natural ☐ Accidental Place of Event, if Accidental: _____

Accidental / Illness Details: _____

_____

Date of occurrence of disability / illness: _____ Last Day of Work: _____

Date of Joining Usual Work: _____ Nature of Work: _____

Have any life coverage with some other insurance company? (If Yes, provide detail)

Sr. No.	Name of Company	Policy No.	Issuance Date	Address and Contact No.
1				
2				
3				

Provide following details while consultation with any physician details of present illness and disability:

Sr. No.	Name of Hospital / Doctor	Complaint About	Treatment Duration	Contact No.	Breif Description about Present Condition
1					
2					

DECLARATION: I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from any doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of health/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the giving of such information.

_____ _____

Claimant Signature **Date of Statement**

(For Group Life, need duly stamped)

CLAIM FORM B: PHYSICIAN STATEMENT

(To be completed by the Attending Physician)

CLAIMANTS INFORMATION:

Claimant Name: _____

CNIC # : _____ Contact No. : _____

Gender : _____ Marital Status: _____

D.O.B : _____ Occupation: _____

EVENT INFORMATION

Events Dates:

Date of Event (Injury / Illness) : _____

Date on which claimant was unable to work: _____

Date on which claimant will be fit to perform office work: _____

Claimant first visit for present illness / injury : _____

Claimant last visit for present illness / injury : _____

Briefly describe the state of health of claimant since his/her first visit: _____

Give Symptoms, Diagnosis and Prognosis of Disability: _____

BMI: Height: _____ Weight: _____

Other Laboratory Findings (X-ray, ECG etc): _____

Please provide detail if any other physician attended claimant for any injury / illness:

Sr. No.	Name of Hospital / Doctor	Treatment Duration	Contact No. & Address	Cause
1				
2				

DECLARATION:

I _____ medical attendant of the life insured _____ do hereby declare that to the best of my knowledge and belief the information given herein are true and complete.

Signature & Duly Stamp with date:

TPL Life Insurance Limited (Formerly AsiaCare Health & Life Insurance Company Limited)

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