NATIONAL INSURANCE COMPANY

Life & Pensions

Claimant Statement

Disability

POLICY NUMBER(S)

1. DETAILS OF THE LIFE ASSURED

Title: _____ Surname: _____

Forenames: _____

Date of Birth: _____ National Identity Card No: _____

Address: _____

Tel No. (M):_____Email Address: _____

Last Occupation attended prior to Event: _____Date last attended work: _____

Please list your main duties: _____

Apart from the above job, please supply a brief history including previous positions held.

Dates		Company	Position held	Type of work done (e.g. welding)
From	To			

Name & Address of Employer: _____

Is impairment caused by Sickness or Accident: _____

Exact Diagnosis: _____ Date of Diagnosis or Event: _____

Provide details of any associated sickness: _____

Date when you first consulted a medical doctor for this condition: _____

What type of treatment are you currently receiving? _____

_____

Has the treatment for your condition ceased? Yes/No. If Yes, please provide details below:

_____

Name & Address of all treating doctors:

	Name	Address
1.		
2.		
3.		

Do you anticipate returning to work? Yes / No. If yes, please provide details:

_____

What prevent you from performing your occupation? _____

Are you currently receiving any state pension or social aid in relation to your health condition? YES ☐ NO ☐

2. GENERAL DETAILS

Do you have life coverage with other insurance company? Yes / No. If yes, please provide details below.

Name of Insurance Company	Sum Assured

3. CLAIMANT DETAILS (If differs from Life Assured)

Title: _____ Surname: _____

Forenames: _____

Date of Birth: _____ National Identity Card No: _____

Address: _____

Tel No. (M):_____Email Address: _____

Relationship with Life Assured: _____

4. DECLARATION

I hereby declare that I am the life assured and that all the particulars given by 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 been omitted. I agree that the furnishing of this form or any other forms supplementary thereto by the National Insurance Co. Ltd shall not constitute nor be considered as an admission of the said claim. I further authorize any past doctor / medical or any other relevant Institutions / past or present employer(s) / any other insurance company to provide any information concerning the life assured's health records for the assessment of the claim being submitted.

Signature of Claimant: _____ **Date:** _____

5. FOR OFFICE USE

Claims Checklist (Tick as appropriate - √)		**YES**	**NO**
1	*Claimant Form been **fully completed***		
2	*Physician Statement (completed by treating doctor) attached or handed over to claimant*		
3	*Medical Certificates attached & certified*		
4	*Request for Medical Report Form attached*		
5	*Evidence of state invalidity Pension*		
6	*Original Policy Contract attached (In case of loss of Policy Contract – PF77 & Disclaimer Form*		

I confirm that the claim documents submitted are complete and copies provided are of good quality.

Name of NICL Representative: _____ Signature: _____ Date_____

Branch: _____ Remarks: _____