Maritime Life (Caribbean) Ltd.
P.O. Box 710, Port-of-Spain

**POLICY NO:** ____________________

# ADmed CLAIMANT'S STATEMENT

(To be completed by the Insured)

1. **The issue of this form is in no way an admission of liability**
2. **Please return the form within 90 days from the date of first expense. Failure to provide full information may delay claim consideration.**

## A. PERSONAL DETAILS:

Name (Mr. / Mrs. / Miss) Date of Birth / /

SURNAME FIRST MIDDLE YEAR MONTH DAY

ADDRESS: ____________________

PHONE NO: (HOME) ____________________ OCCUPATION: ____________________

(WORK) ____________________

(CELL) ____________________

Have you previously submitted proof of age? Yes No If "No" please submit one of the following: Birth Certificate (affidavit where necessary) or Passport

Please tick which benefit is being claimed: Surgical ❑ Hospital Diagnostics ❑ Accident & Emergency ❑

## B. CLAIM DETAILS:

1. Describe fully the symptoms, nature and extent of the illness / injury requiring treatment.

2. If Accident, please give details:

3. On what date did these symptoms first appear?

4. On what date did you first consult a doctor for this Illness/injury?

5. Was this your usual Medical Doctor? Yes No

6. Were you informed of the Diagnosis? Yes No (If, YES, give name and date of diagnosis)

7. Please lists any tests or investigations you have undergone to confirm the diagnosis:

8. Was surgery performed? Yes No If YES, give name and date of procedure.

9. Have you previously suffered from, or received treatment for, a similar or related illness or injury? Yes No If YES, give name of doctor and date consulted.

## C. MEDICAL CONSULTATIONS:

**Name and Address of your usual Medical Doctor**

**List all Doctors consulted and Medical Institutions where you were treated for this illness/injury.**

| NAME | ADDRESS | DATE OF CONSULTATION/ ADMISSION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## D. GENERAL:

1. Have you smoked cigarettes within the last year? Yes No

## E. INSURED'S DECLARATION AND CONSENT

I DECLARE that to the best of my knowledge and belief all the answers in this statement are accurate, true and complete in all respects.

I CONSENT to MARITIME LIFE (CARIBBEAN) LIMITED seeking medical information from any physician who, at any time, has attended me concerning anything which affects my physical or mental health, or any hospital or clinic, where I have been a patient for diagnosis, treatment, disease or ailment, or seeking information from any insurance company to which a proposal has been made for insurance on my life and I authorise the giving of such information.

DATE WITNESS INSURED

## F. DECLARATION ON SUBMISSION OF A BILL BY THE MEDICAL INSTITUTION

I, ______________________________ do hereby confirm that the services billed for by

Amounting to $ ____________________ were received by me and that my Admed card No. ____________________

was used in the transaction.

DATE LIFE ASSURED POLICYOWNER (IF OTHER THAN LIFE ASSURED)

Revised 1/2010