

LOSS OF LICENCE CLAIM FORM

PARTICULARS OF CLAIM	
Claim No. _____ Policy No. _____	
1. Name of Insured in Full :	
2. Residential Address :	
3. Business Address :	
4. Profession or Occupation :	
1. State nature of illness	
2. Have you ever suffered from the same or a similar complaint before?	
3. Are you insured elsewhere against illness? If so, give particulars.	
4. State the first day you were attended by a doctor and the name of the doctor.	
5. Has he or any other doctor attended you during the last five years for any illness or injury? If so, give particulars.	
6. Have you, as the direct result of the illness, been totally incapacitated from attending to business of any kind? If so, state for how long?	From _____ To _____
7. Are you still totally incapable of attending to business of any kind?	
8. State if (a) confined to bed (b) confined to house	From _____ To _____ From _____ To _____
9. If now able to attend to any portion whatever of your business or occupation, state when you commenced to do so.	
10. When and where can you be visited by our Medical or other Officer?	
11. If you are prepared to agree to an immediate settlement please state the amount you are willing to accept.	

I CERTIFY that to the best of my belief the foregoing statements are correct

Date _____

Signature _____

This form is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible.

1. Name of the Claimant	
2. Nature of illness	

RELIANCE General Insurance

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3. Please state the date on which the illness commenced	
4. When did Claimant first consult you in connection of present illness?	
5. Present condition (state as clearly as possible)	
6. Are you the usual Medical Attendant? If so, how long have you known him?	
7. Has the claimant in previously suffered from this complaint? If so, please state when?	
8. Is the claimant suffering from any disease irrespective of the present illness, or are there any other circumstances which may tend to delay recovery? If so, please give particulars.	
9. Is the claimant in your opinion unable to give any attention to his profession or occupation, as described on the front page, please state :- (a) date of commencement of total disablement (b) Probable future duration	
10. State if the claimant is by your advice: (a) Confined to bed (b) Confined to house	From_____To_____ From_____To_____
11. If the Claimant is now able to take any part whatever in his profession or occupation please state from what date?	
12. Remarks	

Name of the Attending Doctor

Qualifications

Signature_____

Address_____

Date
