



POLICY NUMBER: _____

HEAD OFFICE: 29 St. Vincent Street, Port Of Spain, Republic of Trinidad and Tobago, W.I., Tel: (868) 623-1421, Fax: (868) 627-3821, Email: info@clico.com, Website:clico.com

DISMEMBERMENT/LOSS OF USE - CONFIDENTIAL PHYSICIAN'S REPORT BLINDNESS

PERSONAL DETAILS							
INSURED	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; font-size: small;">First Name</td> <td style="width: 50%; text-align: center; font-size: small;">Middle Name</td> </tr> <tr> <td colspan="2" style="height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: small;">Last Name</td> </tr> </table>	First Name	Middle Name			Last Name	
First Name	Middle Name						
Last Name							
ADDRESS:							
No.	street	city	country				
MAILING							
No.			country				
street		city	country				
PHONE NO: (____) _____		DATE OF BIRTH: ____/____/____					
country code	number	month	day	year			

In order for a claim for blindness to be paid under this critical illness insurance policy, the following definition must be satisfied:

Loss of Use shall mean permanent, total and irrecoverable loss of use, beyond remedy by surgical or other means

With regards to hands and feet, loss shall mean dismemberment by severance at or above wrist or ankle joints respectively; with regard to sight, speech and hearing, total and irrecoverable loss

Permanent and uncorrectable loss of sight in both eyes, as confirmed by an ophthalmologist licensed and practicing in Trinidad and Tobago. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.

1. (a) When did your patient first consult you for any eye problem?

(b) How long has this person been your patient?

2. On what date did your patient first suffer symptoms or become aware of any eye problem? Please provide details.

3. (a) What is the correct vision or the field vision in each eye?

(b) On what date was this test performed?

(c) Please provide the name and address of the ophthalmologist.

(d) What is the cause of the blindness, accident/illness?

(e) Is the blindness permanent?

(f) Is there any treatment that could improve your patient's vision?

4. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this vision loss or any related disorder.

5. Please describe, including dates, any predisposing disorders or risk factors that your patient had for blindness.

6 State the periods in which the patient was confined to hospital, bed or home.

7. (a) Is there a family history of eye disorders? Please provide details.

(b) Please provide details of any significant family history.

8. When do you expect the patient would return to work?

8. Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports for our Consultant's review within the last six (6) months..

Our contract requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient: Yes No

Signature: _____

Dated: _____

Name (in block capitals please): _____