ATTENDING PHYSICIAN'S STATEMENT

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT

1. Patient's Name and Address	Age

2. Diagnosis of present disabling condition

3. Additional conditions which might affect the duration of disability

4. (a) Date of first visit :(DD/MM/YY) ________/________/________

(b) Date of last attendance :(DD/MM/YY) ________/________/________

(c) Were you actively supervising this patient's care during the full period of illness?
If "No" , comment in REMARKS below.

5. If condition is due to pregnancy, what is (or was) the expected date of confinement? (DD/MM/YY) ________/________/________	6. Date hospitalized (DD/MM/YY) ________/________/________

7. If surgery was performed, describe procedure : Date (DD/MM/YY):______/______/______	8. If referred to you, give name of referring physician:

9. (a) To the best of my knowledge, the patient has been TOTALLY DISABLED (unable to work)
from (DD/MM/YY)________/________/________ to (DD/MM/YY) ________/________/________ , inclusive

(b) If still disabled give approximate date that patient should be able to return to work
(DD/MM/YY):______/______/______

10. How long was or will patient be PARTIALLY DISABLED?
from (DD/MM/YY)________/________/________ to (DD/MM/YY) ________/________/________ , inclusive

11. To the best of my knowledge : (a) Symptoms first appeared or accident occurred : ____________/____________/____________ Day Month Year	(b) Patient has had same or similar condition : If "Yes" state when, and describe.
REMARKS	Physician's Name (Please Print): Address : Phone Number : Signature : Date :

DATE ____________________

SIGNATURE OF PATIENT ____________________

CLICO (TRINIDAD) LTD.
29 St. Vincent Street

CREDITOR'S LIFE PLAN – DISABILITY CLAIM FORM

(P.O. Box 443)
Port of Spain
Phone: 623 1421-7 or 625 4444
Fax: 627 3821 or 625 4444 ext. 1618

STATEMENT OF CREDITOR'S CLAIM
(DISABILITY)

To be completed by Policyholder

Group Policy Number		
Name of Debtor		
Address		
Date of Birth	Date of 1st Occurrence of Disability	
Date last actively at work, at his normal place of employment		
Reason for cessation of work		
Date loan was disbursed		
Original Amount of Net Loan $		
Duration of loan	years	months
Date First Payment was due		
Amount of Monthly Payments $		
Number of Monthly Payments made		
Total Amount of Net Loan Repaid $		
Number of Monthly Payments in Arrears		
Outstanding Balance at ______/_____/_____ (dd/mm/yyyy) $		
Amount of Insurance on Outstanding Balance $		

Date ____________________	Branch ___________________________
Authorized Signature	Creditor's Stamp

Attach certified copies of the debtor's certificates and other supporting documents.