Credit Protection Plan Claim Form ☐ **Total & Permanent Disability**	**Enclosed documents:** ☐ Copy of Credit Protection Plan Contract	☐ Medical details from attending physician ☐ Letter from Employer confirming date of early retirement + leave records for the last 2 years ☐ Medical Certificate Form ☐ Photocopies of all laboratory & radiology reports
	Outstanding balance: Rs.	Arrears > 3 months (if any): Rs.

To be completed by the Claimant and returned to Anglo Mauritius Assurance Society Limited together with a Medical Certificate Claim form for Total and Permanent Disability completed by the doctor.

Part 1: Details of the Life assured

Contract No.:	Date of birth:	Full name of Hirer:
National Identity Card No.:		
Telephone no.s:		Occupation:
Main Residential Address:		

Part 2: Details of Disability

Cause of Disability: ■ Disease / ☐ Accident	Date of Event:
Please provide full details of all symptoms and type of injuries / impairment:	Date last employed:

Part 3: Medical History

Please give the name(s) and address(es) of doctor/specialist(s) consulted due to this current condition:

Date of Consultation	Name of Doctor / Specialist	Address

Part 4: Skills and Experience:

Level of education:	Details of other skills and profession:
Number of working years experience held for last occupation:	

Signed (Hirer/Claimant):	Date:

Medical Certificate - Total and permanent Disability Claim

Part 1: Personal Details

Name of Patient/Life assured:	Date of Birth:

Dear Doctor,
The above named is insured with Cim Life. A claim has been submitted in connection with a Total and Permanent Disability and to enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

Please forward to us the completed form together with a note of your fees.

Part 2: Medical Details

What is the nature and extent of the patient's condition?	Please give the precise diagnosis
How long have these symptoms been present?	
Please describe the impairment currently disabling the patient	Has the patient previously suffered from any related illness or from other condition? If yes, please give full details.
Based on the physical test, please describe the patient's residual disability:	

Part 3: Nature of treatment

Nature and type of treatment being administered	Please comment on response to treatment
Would you comment on the following: Chance of Recovery:	Is an improvement foreseeable:

Part 4: Details of Physical Impairment

Taking into consideration the patient's occupation, do you feel his/her health condition prevented him/her from carrying out all of his occupational duties?
☐ **YES** / ■ **NO**

If **yes**, please give a detailed explanation:

Please comment on the patient's ability to perform the following:

1. Capable of heavy manual duties:

2. Capable of light manual duties:

3. Capable of sedentary duties:

Part 5: Prognosis

Is the patient totally unable to perform any occupation? ☐ **YES** / ■ **NO**

Do you anticipate any improvement in the condition so as to enable a return to work? If yes, please provide necessary details:

Part 6: Rehabilitation

Is the patient currently undergoing any form of rehabilitation? ☐ **YES** / ▪ **NO**

Please comment on any further treatment or rehabilitation, which may improve the patient's condition:

Please provide any additional information or copy of medical test results which in your opinion could assist our Claims Department in assessing this claim:

Name of Examiner:

Address:

Date:

Signature: