

# Physical Impairment Claim Form

**KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW.**

- Certified copy of policyholder's identity document
- Certified copy of claimant identity document
- Original medical reports
- Medical reports from medical specialists

*Liberty Life reserves the right to call for additional documents where necessary in order to validate the claim*

Policy number

## LIFE ASSURED DETAILS

Surname

First name  Gender  M  F

Identity number  Date of birth  D  D -  M  M -  Y  Y  Y  Y

Telephone number  Mobile number

E-mail address

Postal address

Postal code

## CLAIMANT'S DETAILS *(Must always be policyholder, except where the policyholder is incapacitated or deceased)*

Surname

First name  Gender  M  F

Identity number  Date of birth  D  D -  M  M -  Y  Y  Y  Y

Telephone number  Mobile number

E-mail address

Postal address

Postal code

Relationship to policyholder

## CLAIM PAYMENT DETAILS *(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person. Please indicate with a (✓) the selected payment method)*

### PAYMENT METHOD

- EFT  Mobile Money  Cheque

### BANK DETAILS FOR EFT PAYMENTS

*(Please attach a copy of the latest bank statement - must not be older than 3 months, or confirmation of account details on the Bank's letterhead.)*

Name of account holder

Name of bank

Account number

Branch name  Branch code

Account type

**MOBILE MONEY PAYMENT DETAILS**

Name of account holder

Mobile Money service provider

Mobile Money account number

**CLAIM DETAILS**

**PLEASE INDICATE THE IMPAIRMENT BENEFIT YOU ARE CLAIMING FOR**

Loss of sight in both eyes     Loss of sight in one eye     Amputation of all fingers including thumb     Loss of hearing in both ears

Loss of hearing in one ear     Amputation of all toes including big toe     Loss of use of two limbs     Loss of use of one limb

Other forms of diplegia     Accidental death     Major burns     Loss of speech

Activities of daily living

**ACTIVITIES OF DAILY LIVING (Complete if selected above. Please note that 4 of these conditions must apply for you to submit a claim)**

Can you wash yourself?  Yes  No

Can you feed yourself or eat independently?  Yes  No

Do you have control over bowel and bladder functions?  Yes  No

Can you transfer yourself from bed to a chair despite assistance of a walking aid?  Yes  No

Can you move independently between rooms on a level surface despite assistance of a walking aid?  Yes  No

Can you independently put on or take off all clothes or shoes, including securing and fastening thereof?  Yes  No

**IMPAIRMENT DETAILS**

Please indicate if the impairment as a result of  Disease/illness  Accident/injury/trauma

**IF MEDICAL CONDITION IS DUE TO AN ACCIDENT**

Date of accident  DD -  MM -  YYYY Time

Place

Provide details of how the accident occurred

What injuries did you sustain?

Was the accident reported to the police?  Yes  No

Name of police station

Case number

**IF MEDICAL CONDITION IS DUE TO A DISEASE/ILLNESS**

Nature and earliest symptoms of the condition

When did you first consult a medical doctor regarding the condition?

Date of earliest symptoms of the condition  DD -  MM -  YYYY Date diagnosis confirmed  DD -  MM -  YYYY

Prescribed treatment you are currently taking/using

## TREATING MEDICAL PRACTITIONERS DETAILS

Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc) consulted in connection with this illness

NAME	SPECIALTY	CONTACT DETAILS	DATE

## FAMILY DOCTOR'S DETAILS

Doctor's full name

Telephone number  Fax

E-mail address

## CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I further understand that any misstatement or non-disclosure of information, which materially affects the assessment of this claim, will entitle liberty life to declare this claim null and void.

Claimant's name and surname

Claimant's signature  Date  -  -

## MEDICAL CERTIFICATE *(Always complete this section)*

Name of patient

Policy number

Date on which the patient first became aware of the injury/condition   -   -

Date of last consultation for the current injury/condition   -   -

Date of last consultation for the current injury/condition   -   -

Date of next consultation scheduled with the patient   -   -

Was the patient referred to you?  Yes  No

Name of doctor who referred the patient

Specialty

Contact number

### IF YES, PLEASE PROVIDE THE REFERRING MEDICAL PRACTITIONER'S INFORMATION BELOW:

Name

Contact number

E-mail address

## HISTORY OF CRITICAL ILLNESS EVENT

What is the patient's diagnosis

Date that diagnosis was confirmed   -   -

Please give details of the nature and extent of the impairment

  
  
  


Is there a previous history of the same or similar medical conditions?

To what is the current injury/condition directly attributable?

Four empty horizontal lines for text entry.

Effect of the symptoms on normal activities of daily living

Four empty horizontal lines for text entry.

Current treatment and compliance

Four empty horizontal lines for text entry.

Future treatment options

Four empty horizontal lines for text entry.

Is the injury/condition permanent? Kindly provide detailed explanation

Four empty horizontal lines for text entry.

Is there any reason to believe that the claimant's illness, impairment or injury is in any way due to or arises entirely or partially from:

- Unlawful alcohol consumption or misuse of drugs or narcotics  Yes  No
- Unlawful alcohol consumption or misuse of drugs or narcotics  Yes  No
- Non-compliance to medical treatment  Yes  No

**PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED**

**ACKNOWLEDGEMENT BY ATTENDING DOCTOR**

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's full name

Registration number

Telephone number  Fax

Policyholder's full name and surname

Doctor's signature  Date  -  -

DOCTOR'S STAMP