EFU LIFE ASSURANCE LTD

DISABILITY CLAIM FORM

POLICY # ☐☐☐☐☐☐ / ☐☐☐ - ☐☐☐

1. Name of the claimant _____2. Date of Birth:_____
3. Occupation at the time of Illness/ accident: _____
4. Detailed nature of duties: _____
5. Date and time of illness/ accident: _____
6. Nature of Disability (Give full description of illness / accident):

   _____

   _____

   _____
7. If disability is a result of accident, please give details:

   a) Nature of accident _____

   b) Date and time of accident_____

   c) Has any report made to the police? If yes then give details: _____
8. If disability is the result of a sickness, state nature of illness and give date symptoms first developed:_____
9. What were the earliest symptoms of your disability: _____
10. When did the symptoms first occur:_____
11. Have you been able to perform any work since onset of disability? Yes ☐ No ☐

    If yes, then give details: _____
12. Date last worked_____ Are you still totally disabled? Yes ☐ No ☐
13. Are you suffering from any of the following disease?

		No	Yes	
a)	Diabetes	☐	☐	If yes, please mention duration: _____
b)	Hypertension	☐	☐	If yes, please mention duration: _____
c)	Ischemic Heart Disease	☐	☐	If yes, please mention duration: _____
d)	Any other disease	☐	☐	If yes, please specify with duration: _____

14. Are you presently confined in a hospital, at home or in a bed? If hospital, name and complete address of the hospital: _____

EFU Life House, Plot No. 112, 8th East Street, Phase I, DHA, Karachi, Pakistan.
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15. Date your physician first treated you for your present disability? _____
16. What were the medications your physician prescribed? _____

    _____

    _____
17. Details of treatment/ operations done? _____

    _____

    _____
18. What injuries have you had prior to your disability? _____

    _____

    _____
19. Are you still under treatment? If yes, then give details of treatment: _____

    _____

    _____

    _____

    _____
20. Please give full name and address of the doctor(s) hospital(s) where you were or are still getting treatment:
    a) _____
    b) _____
    c) _____
21. When do you expect to be able to return to any work? Please give the expected date

    _____
22. Level of education and date education completed:_____

    _____
23. Other special training:_____

    _____

I hereby certify that my answers to the foregoing questions are correct to the best of my knowledge and belief.

_____ _____

Date **Signature of the Life Assured**

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