Ceylinco Life Insurance Limited, Ceylinco Life Tower, 106, Havelock Road, Colombo 5. Co. Reg. No. PB5183 Tel: (011) 2461461 E-mail: service@ceylife.lk Web: www.ceylincolife.com

CLAIMANT'S STATEMENT FOR JEEWA YATHRA/PERMANENT DISABILITY/PARTIAL DISABILITY BENEFIT

Policy Number: ☐

1. THE ASSURED:
   (a) Full Name : .....
   (b) Address : .....
   (c) Tel. No. : .....

2. THE LIFE ASSURED:
   (a) Full Name : .....
   (b) Address : .....
   (c) Tel. No. : .....

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3. DETAILS OF DISABILITY (Please tick '✓' where appropriate)

   (a) The disability suffered was/is due to: ☐ Illness ☐ Accident

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4. DETAILS OF ACCIDENT (If the disability is due to an accident)
   (a) Date : .....
   (b) Place : .....
   (c) Police area : .....
   (d) Was it reported to the Police?.....
   If so, please attach to this application a certified copy of the relevant entry obtained from the officer-in-charge of the police station. If the accident was not reported to the Police, please state reason .....
   (e) Brief description of the accident: .....
   (f) Injuries sustained (The nature of injuries must be given in full):
   .....
   .....
   .....

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5. DETAILS OF ILLNESS (If the disability is due to illness)
   (a) Brief description of illness: .....
   .....
   .....
   (b) Have you undergone any tests/investigations to confirm this diagnosis?
   If so, please give illness: .....
   .....
   (c) When did the symptoms first commence?.....
   (d) Have you suffered from the same or any similar condition previously? If so, please provide details of physician/s consulted or hospital/s admitted to.

   (Please forward any available copies of medical reports)

Name	Address	Consultation/Admission Date
.....	.....	.....
.....	.....	.....
.....	.....	.....

(e) Details of your regular physician/s or any other attendant/s consulted for any other disorders in the past three years.

Name	Address	Reason for Consultation
.....	.....	.....
.....	.....	.....
.....	.....	.....

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6. DETAILS REGARDING HOSPITALISATION (For Present Disability)
   (a) Were you hospitalised? If so, where?.....
   (b) Are you still hospitalised? .....
   (c) If not, when were you discharged? .....
   (d) Were you discharged at your request?.....
   (e) If so, what was the reason for the request?.....
   .....

   (Please attach hereto a photocopy of the diagnosis ticket issued by the hospital/s at which you received treatment for the injury/illness. The original ticket must be produced for inspection if the company makes such a request.)

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7. Give details of the disability and/or deformities that you have sustained as a result of this accident or illness: .....
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8. EMPLOYMENT/FINANCIAL DETAILS
   (a) Do you anticipate returning to work? If so, from when?.....
   (b) What aspect of your disability prevents you from following your occupation?
   .....
   .....
   .....
   (c) Do you intend to seek alternative employment?.....
   (d) Please provide details of any other insurance policies under which you may receive payment for this condition?.....
   .....

I/We the Assured/Life Assured named herein declare that the statements and answers given above are true and complete to the best of my/our knowledge and belief, and that I/we have not made any false or fraudulent statements, nor any suppression or concealment of facts.

I/We consent to the company seeking information from any medical practitioner, surgeon, hospital or clinic or from any insurance company or organisation and I/we authorise the furnishing of such information.

....

Signature of Witness Signature of the Assured/Life Assured

Name : ..... Date: .....

Address : .....

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