canopy *health* insurance

GROUP CRITICAL ILLNESS CLAIM FORM

PLEASE USE BLOCK LETTERS, TYPE OR PRINT WHEN COMPLETING THIS FORM

EMPLOYEE'S STATEMENT

Name of Employee

Tax Registration Number

Occupation

Email

Telephone (Home)

(Work)

(Cell)

Name of Employer

Employer's Address

TYPE OF ILLNESS FOR WHICH CLAIM IS BEING MADE (PLEASE TICK APPROPRIATE BOX)

- ☐ Blindness
- ☐ Cancer
- ☐ Coma
- ☐ Deafness
- ☐ Heart Attack
- ☐ Loss of Speech
- ☐ Major Burns
- ☐ Multiple Sclerosis
- ☐ Permanent Paralysis
- ☐ Stroke

D D M M M Y Y

Date of injury or initial date of illness

Y N

Is injury or illness as a result of an accident?

Give full particulars of present illness, and describe in detail the symptoms from initial onset to present time

Are you now:

- ☐ Confined to bed
- ☐ Confined to house
- ☐ Hospitalized

Please provide details of the illnesses, injuries, disabilities that you have had during the last three (3) years.

Have you ever been a patient of a hospital or medical facility? If so, give dates and names of the medical facilities.

I certify that the above answers are full and true to the best of my knowledge and understand that payment will be made in accordance with the terms and conditions of the group policy.

I hereby authorize and direct my Employer, institutions, and without limiting the generality of the foregoing, any physician, hospital or government agency, to fully disclose to Canopy Insurance Limited or its duly appointed representative, all information relative to my health and medical history.

Signature of Employee

Name and Signature of Witness

Date

ATTENDING PHYSICIAN'S STATEMENT

COMPLETION OF THIS FORM IS NOT AT THE EXPENSE OF CANOPY INSURANCE

Name of Patient

FIRST NAME | MI | LAST NAME

DATE OF BIRTH (D D M M M Y Y) | GENDER (M F) | WEIGHT | HEIGHT

HISTORY

(A) DIAGNOSIS

(B) DATE OF FIRST DIAGNOSIS (D D M M M Y Y)

(C) DATE EMPLOYEE CEASED ATTENDING WORK DUE TO DIANOSIS (D D M M M Y Y)

(D) HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES", STATE WHEN AND GIVE DETAILS BELOW:

ANY ADDITIONAL COMMENTS BY ATTENDING PHYSICIAN:

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

Attending Physician's Signature | Date

Address | Company Stamp