TIP Friendly Society
80 Half Way Tree Road, Kingston 10
Tel: (876) 920-8399, (876) 960-0729
Toll Free: 1-888-991-4189

PERSONAL ACCIDENT &/OR SICKNESS CLAIMANT STATEMENT

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. **This form consists of several sections. Please provide answers to all of the following information required in order to avoid delays with your claim. Please note that Parts A, D & E are compulsory.**
2. Please fill out this form completely and accurately; write N/A in areas that do not apply.
3. Only original receipts are accepted with Claim Form.
4. The issue of this form is not an admission of liability by TIP Friendly Society.

PART A: PLAN AND PERSONAL INFORMATION – COMPULSORY SECTION – REQUIRES COMPLETION

1. **Plan Name & Number:** _____
2. Name of Member: _____
3. Name of Insured Person: _____
4. Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____
5. Residential Address: _____
6. Telephone Number: Home: _____ Mobile _____ Email: _____
7. Employer: _____ Nature of Business: _____
8. Business Address: _____
9. Telephone Number: Business _____ Mobile _____ Email _____
10. Occupation, Trade or Profession: _____ Average Weekly Earnings _____
11. Describe Duties: _____

PART B: TO BE COMPLETED ONLY IF DISABILITY IS AS A RESULT OF AN ACCIDENT/INJURY

12. Address where Accident occurred: _____
13. Time: _____ a.m. / p.m. Date _____ / _____ / _____
14. Describe briefly how the Accident happened: _____
15. What bodily injuries did you sustain? _____
16. Is there visible evidence of contusion or wound? ☐ Yes ☐ No If yes, describe _____
17. If partial disability is claimed, state the particular duties you were unable to perform during the entire period of disability: _____
18. Were you on vacation or unemployed during any period of disability? _____
19. Has disability resulting from Accident ended and is this your full claim? ☐ Yes ☐ No
20. How long were you totally disabled? _____ weeks _____ days

PART C: TO BE COMPLETED IF DISABILITY IS AS A RESULT OF A SICKNESS/ILLNESS

21. The nature of illness: _____
22. When did illness begin? _____ Have you had this complaint before? ☐ Yes ☐ No
23. If yes, how long were you disabled? _____

PART D: TREATMENT – COMPULSORY SECTION – REQUIRES COMPLETION

24. Was hospital treatment required? ☐ Yes ☐ No
25. If yes, please complete the following regarding your hospital stay (please attach separate sheet if insufficient space):

From	*To*	*Hospital Name*	*Hospital Address*

26. Give details of all attending physicians consulted for present condition (please attach separate sheet if insufficient space):

Dates	*Physician Name*	*Address*	*Telephone Number*

Please Turn Over...

PART D: TREATMENT – COMPULSORY SECTION – REQUIRES COMPLETION (CONT'D)

27. Give details of any claim made for present condition against any other insurance company (please attach separate sheet if insufficient space):

Name of Company	*Address*	*Amount of Weekly Indemnity*

28. Were you confined at home? ☐ Yes ☐ No If yes, please state time period: from _____ to _____

29. When did you stop performing all your occupational duties? Time: _____ a.m. / p.m. Date ____ / ____ / ____

30. Describe fully your present condition _____

31. Has any member of your family been afflicted with a similar disease? ☐ Yes ☐ No

32. If yes, please state _____

33. Have you seen a Physician within the last three years for reasons other than your present condition? ☐ Yes ☐ No

34. If yes, please complete the following:

Physician's Name	*Address & Telephone*	*Date*	*Reason*

35. Have you done any work since commencement of disability? ☐ Yes ☐ No If yes, explain: _____

36. During your period of disability, how did you spend your time? _____

37. Are you now:

Recovered	☐ When did you return to work?	Date ____ / ____ / _____
Partially Disabled	☐ When did you return to work to undertake part of your normal activities?	Date ____ / ____ / _____
Totally Disabled	☐ When do you expect to return to work?	Date ____ / ____ / _____

PART E: DECLARATIONS – COMPULSORY SECTION – REQUIRES COMPLETION

PLEASE ENSURE THAT THE PHYSICIAN STATEMENT IS COMPLETED BY THE PHYSICIAN WHO YOU CONSULTED FOR THIS INJURY OR SICKNESS

Privacy
TIP Friendly Society collects your personal information in order to calculate your loss and entitlements, determine our liability and handle claims. When handling your claim, we may have to disclose and obtain your personal and other information to and from third parties such as other insurers, reinsurers, loss adjusters, medical attendants, or other parties as required by law.

Authority
I authorise TIP Friendly Society to contact any Physician or medical attendant who has treated me or examined me or any person or organisation that employs or has employed me or any other person or organisation who has or may have information regarding my illness/injury for any information it may require to assist in the proof and settlement of my claim. A photocopy or faxed copy of this authority can be acted upon as it was an original.

Declaration
I/we certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld.
I/we understand that this claim may be refused/denied if information is found to be untrue, inaccurate or concealed.
I/we acknowledge that I/we have read and understood the Privacy Section information and Authority referred to above and consent to the collection, storage and use and disclosure of my/our personal and sensitive information. I/we acknowledge that if I/we do not agree to the collection of this personal information, then TIP Friendly Society shall not be held liable for any settlement of claim.

Signature of the Insured (If other than Claimant) _____ Date _____ / _____ / _____

Signature of the Claimant _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____