Life Insurance Disability Claim Form

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life PNG Limited, Waigani Banking Centre | Section 34, Allotment 6&7, Klinki Street, Waigani Drive
P O Box 78, Port Moresby, National Capital District, Papua New Guinea.
Telephone: (675) 3056214 Email: servicebsplife@bsp.com.pg

PLEASE READ THESE NOTES

- Please complete all details in BLOCK LETTERS.
- This form is to be completed by the Policy Owner.
- The Medical Provider Statement must be completed by the attending [1]Medical Provider and to be returned to BSP Life at the address above.
- You have a duty to disclose to the Insurer every matter that you know, or could reasonably be expected to know, which is relevant to the Insurer's decision on whether to admit or decline this claim.
- If you fail to comply with your duty of disclosure we may void the contract depending on whether your non-disclosure was fraudulent.

Insurance Agent		**Policy Number**	

SECTION A. DETAILS OF LIFE INSURED

Personal Details

Title:	First Name:	Middle Name(s):
Last Name:		Date of Birth:

SECTION B. DETAILS OF POLICY OWNER

Personal Details

Title:	First Name:	Middle Name(s):
Last Name:		Date of Birth:

Contact Details

Work Telephone	Direct Office Telephone
Mobile	Email

SECTION C. ACCIDENTAL TOTAL AND PERMANENT DISABILITY CLAIM

1. State the nature of the injury which caused you to cease your work/current duties.

2. When did the accident happen that caused your injury?

3. Have you previously had this injury which has been aggravated by the accident? ☐ Yes ☐ No ► *If Yes, please provide details.*

[1] *Medical Provider means either a Doctor, Physician, General Practitioner, Medical Attendant, Specialist, Clinic or Hospital.*

4. Do you expect to return to work or your current duties:

5. Are you entitled to any other disability benefit or compensation under the Workers' Compensation Act? ☐ Yes ☐ No ► *If Yes, please provide details below.*

Name of Insurer

Telephone **Email/Facsimile**

Postal Address

6. State names and addresses of Medical Providers attending to you who would be able to provide information regarding your condition and treatment.

Name of Medical Provider	Address	When Treated	Nature of Treatment

7. Are you required to regularly attend any surgery, hospital or clinic for treatment? ☐ Yes ☐ No ► *If Yes, please provide details below.*

Name and Address of Medical Provider	How Often	Treatment (X-Ray, injection etc)

8. Please describe your work/current duties in detail and whether or not you use special equipment or tools: *(Please list).*

Details of Current Work/Duties	Tools/Equipment Used

9. Does your work/current duty involve any physical requirements (e.g. lifting or carrying load)? ☐ Yes ☐ No ► *If Yes, please provide details below.*

10. Have you been able to perform any of your work/current duties since your disability happened? ☐ None ☐ Part Time ☐ Full Time

SECTION G. CLAIM PAYMENT DETAILS

(Policy Owner to Complete)

Bank Name **Bank Account Name** **Bank Account Number**

SECTION H DECLARATION AND AUTHORISATION

(Benefit Payment will only be made if premium payments are in order)

I understand that Benefit payments will only be made to the Policy Owner.

I declare that the information provided in this form is true, complete and correct.

I understand that BSP Life will use the information provided in this form for the purpose of evaluating the claim.

I authorise any medical professional, hospital or other medical care institution, medical laboratory, insurance support organisation, pharmacy, government agency, insurance company, employer or benefit plan administrator, to provide to BSP Life any information concerning my/the Life Insured's employment, or insurance or any medical information to determine the benefits applicable under the Policy. **I confirm** that I am duly authorised to provide this statement.

I agree that a photocopy of this authority will be as valid as an original.

Life Insured:

Signature	Signed at:
	Date:
Name	
Address	

Policy Owner (if not Life Insured)

Signature	Signed at:
	Date:

Witness

Name	
Signature	Signed at:
	Date:

MEDICAL PROVIDER STATEMENT

(To be completed for Accidental Total and Permanent Disability)
Please ask your Medical Provider to complete this statement. BSP Life is NOT liable for any charges levied by your Medical Provider.

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. What is your patient claiming?

   ☐ Total and Permanent Disability (TPD) ☐ Personal Accident (PA) Scale _____

2. Patients Name: _____ Date of Birth: _____

3. Diagnosis or nature of injury: *(Please indicate primary and secondary)*

4. Date of injury?

5. How long have you known the patient?

6. Date patient consulted you for this injury:

   First Consultation:

   Last Consultation:

7. List all the dates on which the patient has consulted you for this injury:

Date	Treatment Received	Date	Treatment Received

8. Are you treating the patient for this injury? ☐ Yes ☐ No

9. Was this injury an emergency? ☐ Yes ☐ No

10. Objective findings: *(Please give details of any X-Ray, ECGs or Other Tests)*

Date	Test	Results

11. Nature of treatment: *(Please include any complications)*

12. Has the patient consulted you for any other condition in the past five (5) years? ☐ Yes ☐ No ► *If Yes, please give details below.*

Reason for Consultation	Date Consulted	Treatment/Advice Received

13. Is this current injury a recurrence? ☐ Yes ☐ No

14. Has the patient had a similar injury? ☐ Yes ☐ No ► *If Yes, please give details below.*

Date	Nature of Injury or Illness	Treatment Results

15. Are there any other conditions or circumstances affecting recovery from the current injury? ☐ Yes ☐ No ► *If Yes, please advise nature of condition or circumstance and how it affects recovery.*

16. Date of Total Disability:

From: To:

17. Date of Partial Disability:

From: To

18. Additional Remarks

19. Medical Provider's Name:

Telephone: Email/Facsimile:

Postal Address:

Medical Provider's Signature: Date:

Registration No.: Stamp:

INSTRUCTION TO MEDICAL PROVIDER

Please send the **Medical Provider Statement** in an envelope marked "CONFIDENTIAL" to:

The Insurance Benefit Manager
BSP Life PNG Limited
Level 2 Waigani Banking Centre, Section 34, Allotment 6 & 7, Klinki Street, Waigani Drive
P O Box 78, Port Moresby, National Capital District, Papua New Guinea

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