Bermuda Life Insurance Company Limited
The Argus Building
14 Wesley St., P.O. Box HM 1064
Hamilton HM EX, Bermuda
Tel: (441) 295-2021
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CLAIMANT'S STATEMENT OF DISABILITY

1. Claimant's Name: _____ Date of Birth: _____ (dd/mm/yy)

2. Address: _____

_____

3. Employer: _____ Occupation: _____

4. Nature of Disability:

_____

_____

5. Date Last at work: _____ (dd/mm/yy)

   Have you attempted any work activity since this date? ☐ Yes ☐ No

   If yes, give brief details: _____

   When do you expect to resume your regular occupation? _____ (dd/mm/yy)

6. State the name(s), address (es) and first and last date(s) physician(s) were consulted in respect to present disability and hospital visits: (If more space is required, write on the back of this form).

Physician's Name	Address	Dates Consulted (dd/mm/yy)

Name of Hospital	Dates of Confinement	Dates of Visit As Out-Patient (dd/mm/yy)

7. Are you entitled to disability income benefits from any of the following sources? If yes, provide dates of benefit payments.

	Yes	No	Date Payments Commence	Date Payments Cease
Other Group Policy	☐	☐		
Group Pension Plan	☐	☐		
Employer's Liability	☐	☐		
Workman's Comp	☐	☐		
Government Benefits	☐	☐		
Other Sources (specify)	☐	☐		

8. In the event of your death while continuing to receive disability benefits under this policy and providing you have received at least six monthly benefit payments, an amount equal to three times your net monthly benefit will be paid to your surviving dependent spouse and/or children under the age of 19 years or 26 years if a student. Please provide details of your eligible dependents below:

Last Name	First Name	Middle Initial	Gender	Date of Birth (Month/Day/Year)	Relationship

DECLARATION:

I confirm that the statements provided in this claim form and all statements provided by any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge. I agree that all such statements form the basis for any benefits approved as a result of this claim. I hereby authorize the disclosure and exchange of any personal or health information, records, including physician's notes, or knowledge concerning myself between any healthcare provider or professional, medical organization, medical information bureau, insurance or reinsurance company, investigation and credit reporting agency, my employer, as well as any other person, private or public organization or institution and Argus Management Services Limited, its underwriting company, its employees, reinsurers, or any agency acting on behalf of Argus Management Services Limited which is necessary for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning. A photocopy of this authorization will be as valid as the original.

_____ _____

Claimant's Signature Witness

_____

Date