TOTAL AND PERMANENT DISABILITY (TPD) RIDER CLAIM FORM

DATE: _____

Cooperative Name: _____

Exact Address of Cooperative: _____

Coop's Bank Details: Account Name: _____

Account Number: _____ Bank: _____

Name of MEMBER: _____ Coop Membership Date: _____

Beneficiary/Contact Person: _____ Contact Number: _____

Rider: **TOTAL AND PERMANENT DISABILITY (TPD) RIDER**

Coverage: From _____ To: _____

Member's Details of Occupation (Life Insured)

Occupation (Job Title): _____

____ Employed ____ Self-employed

Major duties prior to disability: _____

List of duties unable to do due to disability: _____

Have you ceased all work: ___ Yes ___ No; if yes, please provide date you ceased all work: _____

Have you been able to do any work in any occupation since you were disabled? ___ Yes ___ No

If yes, provide details _____

If no, please provide details of your activities since you were disabled _____

Have you sought alternative employment since leaving: ___ Yes ___ No

If so, please provide details, including any voluntary employment: _____

_____

If self-employed:

What is the nature of your business? __ Sole Trader __ Partnership __Company __others _____

How many employees are there in your business? _____

Please provide all duties of your pre-disability occupation: _____

DETAILS OF DISABILITY

If disability due to ill, please provide the following details:

a. Diagnosis _____
b. Diagnosis date symptom started _____
c. Describe the nature of your illness: _____

If disability due to accident, please provide the following details:

a. Date and time of accident: _____

b. Details of accident: _____

Please provide details of all treatment you are currently receiving including any regular medication being taken

_____

Are you still totally disabled? __ Yes __ No; if yes, when do you expect to resume your work? _____

Details pf Physician Consulted

Name of Physician/Hospital _____ Address: _____

Reason for consultation: _____ Date of consultation: _____

Admission Date/s: _____

Have you ever had this medical condition or any other similar condition before? __ Yes __ No

If yes, please provide details:

Date of diagnosis: _____ Physician's & Hospital Name: _____

Physician's & Hospital Address: _____

Please provide details of all medical treatment (including physiotherapy, acupuncture, chiropractic or any other practicing alternative therapies), and consultation in the last 3 years

Hospital: _____ Address: _____

Reason for consultation: _____ Date: _____

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Requirements:

1. NATCCO MBAI TPD RIDER CLAIM FORM
2. Attending Physician's Statement
3. Photocopy of valid photo-bearing identification document of Claimant/s with 3 specimen signatures
4. Billing/Statement of Account
5. Medical Abstract / Admitting History

Declaration and Authorization

I declare that all answers given by me in this form are true and complete, and to the best of my knowledge and belief all are based on official records.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the industry association database, consumer reporting agency, entity or employer, having information available as to diagnosis, treatment, results and prognosis, with respect to my physical or mental examination or condition, to give to NATCCO MBAI any and all information, or any other information or record it may need.

This form pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases, and any employment and insurance coverage information.

I also authorize NATCCO MBAI to request, secure and to obtain any or all information's, records or documents which are available from any medical practitioner, government/private hospitals/clinics, medical offices/clinics or any investigative report from its duly authorized inspection agency which will provide any applicable information concerning the processing of this claim for insurance benefits on the life of the insured.

I agree that a photographic copy of this Authorization shall be valid as the original. This authorization discharges any such physician, medical practitioner, hospital, clinic, medical office or facility and all members of its staff from any liability or obligation by reason of the release of such information/document/record.

_____

Claimant's Signature over Printed Name

_____

Date Signed

TO BE FILLED OUT BY NATCCO MBAI CLAIMS UNIT:

Valid IDs: Type: _____ ID#: _____

Documents Presented: _____

Documents received and validated by: _____

Date: _____

Notes:

_____

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