INSURANCE COMPANY LIMITED

The Atrium: 32 Trafalgar Road, P.O. Box 254, Kingston 10, Jamaica W.I.
Tel: (876) 935-2004, TOLL FREE: 1-888-MY-NEEDS, Fax: (876)929-7301
E-mail Address: ncbic@jncb.com, Website: www.jncb.com

Claimant's Statement

All Sections up to Section D must be completed.
See additional instructions on pages 3 and 4

1. Policy Number(s):

Claimant Information	Life Insured Information
2. Full Name:	Full Name:
3. Address:	Address:
4. Date of Birth:	Date of Birth:
5. Claimant Relationship on policy (Life Insured, Beneficiary, Trustee, Executor, Assignee, etc.)	6. Name & Address of Life Insured's Personal Physician:
7. Contact Details: Tel: (c) (w) Email:	

SECTION A. TYPE OF CLAIM (Select (√) all boxes applicable to this claim)

8. DEATH ☐ TERMINAL ILLNESS ☐ TOTAL & PERMANENT DISABILITY ☐ CRITICAL ILLNESS ☐ ACCIDENTAL INJURY/DISMEMBERMENT ☐
HOSPITALIZATION BENEFIT ☐ IN-HOSPITAL BENEFIT ☐ AMBULANCE BENEFIT ☐ INVOLUNTARY UNEMPLOYMENT ☐ OTHER (SPECIFY): ☐ ___________________

SECTION B.	Name of Company	Amount	Date of Issue
9. Does the Life Insured have other Life Insurance?			

SECTION C. TO BE COMPLETED FOR ALL CLAIMS (Except Involuntary Unemployment)

10. List all physicians who attended the life insured and all hospitals or other institutions attended while being treated for the illness, injury or condition.

Name	Address	Date of Attendance or Hospitalization	Diagnosis/ Injury

SECTION D. PAYMENT DETAILS (To be completed for all claims)

Payment Instructions	☐Direct Deposit ☐Cheque ☐Manager's Cheque ☐Foreign Draft ☐ Cash ☐ NCBIC Policy		
Payee Name:		**Policy #:**	
Bank Account Detail ☐ Sav ☐ Chq	**Bank:**	**Branch:**	**A/C #:**
	Routing Number:	**Sub Account #:**	

SECTION E. TO BE COMPLETED FOR DEATH CLAIMS

11. Date and Place of Death:			
12. Cause(s) of Death:	a.	b.	c.

13. Are you entitled to the whole proceeds of this policy?
Yes ____ No _____ If no, state percentage being claimed ______ %

14. When did the deceased last complain of or give indication of their last illness?
Day _____ Month _________ Year ________

15. When did the deceased first consult a physician for their last illness?
Day _____ Month _________ Year ________

SECTION F. TO BE COMPLETED FOR CRITICAL ILLNESS, HOSPITALIZATION BENEFIT, AMBULANCE BENEFIT & TERMINAL ILLNESS CLAIMS

16. When did the Life Insured first consult a physician for this illness/condition?
Day_______ Month___________ Year______

17. What is the diagnosis?

18. Was the Life Insured transported in an ambulance in connection with this illness?
Yes_____ No____ If yes, on what date? Day ______ Month ______Year_______

19. Was the Life Insured hospitalized?
Yes_____ No____ If yes, for how long? __________ days

Policy Number(s):

Name of Claimant:	**Name of Life Insured:**

SECTION G. TO BE COMPLETED FOR TOTAL & PERMANENT DISABILITY CLAIMS ONLY

20. Was the Life Insured employed at the time of the accident?
Yes____ No___ If yes, state occupation ____________________________

21. Name and address of the Life Insured's employer

22. Nature of business

23. Describe the duties of the Life Insured

SECTION H. TO BE COMPLETED FOR ACCIDENTAL INJURY (including TOTAL & PERMANENT DISABILITY) and IN-HOSPITALIZATION CLAIMS

24. Date and hour of the accident
Day_______ Month___________ Year______ Hour________

25. Where did the accident occur?

26. How did the accident occur?

27. What bodily injuries did the Life Insured sustain?

28. Was the Life Insured hospitalized?
Yes____ No___ If yes, for how long? __________ days

SECTION I. TO BE COMPLETED FOR INVOLUNTARY UNEMPLOYMENT CLAIMS

29. Life Insured's Employment Category:
Permanent: _____ Temporary: _____ Self-Employed:_____ Other: (Specify) _________________________

Life Insured's Occupation: ______________________________ Salary: ________________________ (weekly, fortnightly, monthly, annual)

30. Employer Details :
Registered Name of Employer: _______________________________
Address 1: ____
Address 2: ____
Contact Number: ____
Fax: ____
Email: ____

31. Self-Employed Details:
Registered Name of Business: ___________________________
Address 1: ____
Address 2: ____

32 Details of Unemployment :
Date of Employment: Day: _____ Month: _______ Year: _________
Date of Termination: Day: _____ Month: _______ Year: _________
Reason/Mode of termination (tick one):
☐Redundancy ☐Voluntary redundancy ☐Retirement
☐Resignation ☐Dismissal for cause (e.g. breach of policy, fraud)
☐Expiration of contract ☐Probation
☐Medical reason (please state):__________________________________
☐Other: ________________________________

33. Details of business insolvency:
Date of Insolvency: Day: ______ Month: ______ Year: _______

34. EMPLOYER/SELF EMPLOYED CONFIRMATION

I, the undersigned, do solemnly declare that the information contained and completed in Section I is full, complete and true.

Name of Officer/Self Employed	**Signature**	**Title**	**Date**
Name of Witnessing Individual	**Signature**	**Title**	**Date**

____
Company Seal /JP Seal

I, the Life Insured/Claimant hereby authorize any Physician, Surgeon or other persons, any hospital, clinic or other institutions to furnish to NCB Insurance Company Limited, any information that may be required concerning the Life Insured's health and medical history. I agree that a photocopy of this authorization shall be as valid as the original.

Signature of Claimant	**Witness (NCB Representative, J.P. or Notary Public)**	**Date**

INSTRUCTIONS

1. All sections up to Section D must be completed

2. The Section/s applicable to the claim must also be completed:

Section E	Death
Section F	Critical Illness / Hospitalization Benefit *1 / Ambulance Benefit / Terminal Illness
Section G	Total and Permanent Disability
Section H	Accidental Injury / Total and Permanent Disability / In-Hospital Benefit *2
Section I	Involuntary Unemployment

*1 Benefit payable on the applicable OMNI product
*2 Benefit payable for In-Hospitalization as a consequence of an accident

3. Claimant's Statement completed outside of the offices of NCB must be witnessed by a Justice of the Peace or Notary Public.

4. See applicable benefit (Living or Death) below for additional claim requirements.

Living Benefit

1. This *Claimant's Statement* form must be completed by the Life Insured or by the Beneficiary in the event the Life Insured has died as a result of a Critical Illness.

2. In addition to this *Claimant's Statement* form the following documents must also be furnished:

   I. The Policy contract document must be submitted to the Company. In the event that the Policy contract is lost or stolen, a DECLARATION RE LOST POLICY DOCUMENT must be submitted.

   II. Proof of Age of the Life Insured (Valid Passport, Birth Certificate and Marriage Certificate where applicable)

   III. Claimant Identification (Valid Passport, Driver's Licence, or Elector Registration Identification)

   IV. ATTENDING PHYSICIANS REPORT *(this form must be submitted directly to NCBIC Head Office, under CONFIDENTIAL cover)*.

   V. If Accident - Accident Report (Police report and/or Accident Report from the Life Insured's employer). Medical Statements supporting Accidental Injuries.

   VI. If Critical/Terminal Illness - Medical Reports and statements confirming the condition being claimed

   VII. If Involuntary Unemployment – Certificate of insolvency of business (for self-employed). For employed individuals, evidence of employment must be provided in the form of a bank statement showing salary paid to the employee's account and/or salary statement over the last 6 months.

3. All information and assistance possible in connection with furnishing proofs of claim will be given by the Company or its agents. However, any expense incurred in furnishing the proof of claim must be borne by the Claimant.

Death Benefit

1. If the Policy is Payable to a Named Beneficiary or Beneficiaries

a) This statement should be completed by the named Beneficiary, unless a minor. If there is more than one Beneficiary, separate forms will be supplied.

b) If any named Beneficiary is a minor, this statement should be completed on behalf of the minor beneficiary, by the guardian or other person authorized by law to deal with minor's property. A certified copy of the Letters of Guardianship must be submitted.

c) If any named Beneficiary is deceased, proof of death of such Beneficiary must be furnished.

2. If the Policy is Payable to the Estate of the Deceased

a) If the Deceased left a Will, this statement should be completed by the Executors under the Will and notarized copy of the Will and Letters Probate must be furnished.

b) If the Deceased did not leave a Will, this statement should be completed by the Administrator of the estate and a notarized copy of the Letters of Administration must be furnished. In jurisdictions where Letters of Administration are not granted, this form should be completed by the heirs of the Deceased and proof as to who the legal heirs are should be submitted.

3. If the Policy is Assigned/Hypothecated

This statement should be completed by the Assignee as well as the beneficiary.

Other Requirements:

4. Documents

In addition to this Claimant's Statement the following documents must also be furnished:

I. Proof of the death of the Life Insured in the form prescribed by the Company (Death Registration Form, Physician's Statement - Proof of Death or Medical Certificate – Cause of Death).
II. If death is reported to be due to accident, a police report of the circumstances surrounding the death.
III. The Policy contract document must be submitted to the Company. In the event that the Policy contract is lost or stolen, a DECLARATION RE LOST POLICY DOCUMENT must be submitted.
IV. Proof of the deceased Life Insured's age in the form of a passport or certified copy of a birth certificate.
V. Where death has occurred within the policy's contestable period, an attending Physician's Report from the deceased's personal physician (while alive), clinic or other medical facility is to be submitted.
VI. Valid beneficiary identification (passport, driver's license, voter's ID)

5. General

I. Any local requirements regarding Succession Duties, Estate Taxes, or Inheritance Taxes must be completed before the Company may make payment of the claim.
II. All information and assistance possible in connection with furnishing proofs of claim will be given by the Company or its agents. Any expense incurred in furnishing the proofs of claim must be borne by the Claimant.