Level 9 FNPF Place, 343 – 359 Victoria Parade, Suva Ph. (679) 330 2717 Fx. (679) 330 2119
Western branch: 117 Vitogo Parade, Lautoka. P.O. Box 7362, Lautoka. Ph. (679) 666 5717 Fx. (679) 666 9711

TOTAL AND PERMANENT DISABLEMENT CLAIM
(Forced Retirement Claim)

Name of Life Insured	Mr/Mrs/Ms	
Telephone:	Home:	Work:
Residential address:		
Date of birth:	/ /	Age:

STATEMENT BY LIFE INSURED

Question	Answer
1. (a) What is the cause of your disability?	
(b) If due to an accident, please describe briefly how the accident happened.	
(c) What was the date of the accident?	
2. (a) What is the name and the address of the doctor you first attended for this disability?	
(b) Are you still attending this doctor? If 'No', what is the name and address of the doctor from whom you are currently receiving treatment?	Yes No
3. Have you consulted any other doctor(s) for this disability? If 'Yes' please list their names and addresses and the dates each doctor was consulted.	Yes No
4. Have you, as direct result of this disability, been totally disabled from working at your normal occupation? If 'Yes' on what date did you cease work?	Yes No / /
5. (a) What is your normal occupation?	
(b) If any, what professional trade qualifications do you have?	
(c) What previous occupations have you had?	Occupation: From / / to / /
	Occupation: From / / to / /
	Occupation: From / / to / /

	Occupation: From / / to / /
	Occupation: From / / to / /
	Occupation: From / / to / /
6. What was your gross income earned through personal exertion for the 12 months immediately preceding the date your disablement commenced?	$
7. As a result of your disablement are you entitled to receive or have you received payment of a capital sum (whether paid in one amount or by instalments) under a Superannuation Fund or Life Insurance Policy issued by an insurer other than FijiCare Insurance Limited. If 'Yes', state (a) Name of Insurer (b) Type of Policy (c) The amount of capital sum	Yes No (a) (b) (c) $
8. As a result of your disability, are you entitled to receive or have you received payment under any Worker's Compensation Act, Salary Continuation Policy or any other Insurance Contract providing replacement income? If 'Yes', state (a) Name of Insurer (b) Type of Policy (c) The amount of weekly/monthly income?	Yes No (a) (b) (c) $ per week/month

DECLARATION AND AUTHORISATION

I hereby authorize any hospital, physician or other person who attended me, any employer, Work Cover or Worker's Compensation Agent or Insurer or Department of Social Security, to furnish FijiCare Insurance Limited or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all record of employers. **I agree that a photo static copy of this authorization shall be considered as effective and valid as the original and authorize its use as such.**

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sickness shall be forfeited.

Signature: ………………………………………………………… Date: ………………………………….

Full Name: *(please print)* ……………………………………………………………………………………………..