GHANA UNION ASSURANCE LIFE COMPANY LIMITED
Head Office
F 828/1 Ring way Estates, Osu
P.O. Box GP 1185, Accra, GHANA
Tel: 0302-764674, 783021; Fax 233-302-764168

TOTAL PERMANENT DISABILITY CLAIM FORM (TPD)

(To be completed by the person legally entitled to the policy moneys)

1. Policy No:
2. Name of Life Assured (in full):
3. Gender: Male/Female
4. Address:
5. Date and Place OF Birth:
6. (a) What was the cause of Total Permanent Disability?

…….

…….

…….

(b) Describe the circumstances leading to the discovery of the TPD

…….

…….

…….

(c) If TPD was as a result of an accident, describe how the Accident occurred. Please submit newspaper reports, if any.

……

……

7. (a) When did the Life Assured first complain of or give indication of the TPD?

…….

(b) When did the Life Assured first consult a physician for the TPD?

……..

(c) Please Give the name and the address of the medical officer who attended to the Life Assured

……

……

8. Is the Life Assured still at post working? When did the Life Assured last attend to his/her usual work?

…….

9. Is an Inquest or medical diagnosis of the Life Assured pending? If already done, please, furnish us a certified copy of the verdict of Findings.

……..

10. (a) In what capacity or by what title do you claim the life assurance?

…….

(b) How long have you known the Life Assured?

……..

(c) What is your present age?

I ----------
the claimant, do solemnly and sincerely declare that the foregoing answers and statements are full and true to the best of my knowledge and belief, and that I have withheld no material fact from the Company.

And I hereby make claim to the said life assurance from GHANA UNION ASSURANCE LIFE COMPANY LIMITED and agree that the written statements and affidavits of all the Medical Doctors who attended to the Life Assured and all documents furnished in support of this Claim, shall constitute part of the proofs of Total Permanent Disability.

11. Signature of Claimant----------

Name of Claimant----------

Occupation/Position----------

Address----------

Date----------

Tel No.: ----------

12. Signature of Witness----------

Name of Witness----------

Occupation/Position----------

Address----------

Date----------

Tel No.: ----------

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MEDICAL CERTIFICATE OF CAUSE OF TPD

I hereby certify that I have medically attended…(Mr/Mrs/Miss)……

of
……

apparently or stated to be aged……years; that I last saw him/her last on

the…….....day of ……20…; that he/she was suffering

from……

which has resulted in:

☐Total Permanent Disability ☐No Total Permanent Disability

By my knowledge and belief as herein stated,

Diagnosed Disease or condition	(i)…… due to (or as consequence of)	Approximate interval between onset and death ……..
Antecedent causes: Morbid conditions, if any, giving rise to the above cause.	(ii)…….. due to (or as a consequence of)	……
Other significant conditions Contributing to the current state	(iii)……..	……..

Witnessed by my hand this…….day of ……....20…...

Name and Medical Qualification……

……

Signature…….. Date……

Address……Tel. No.:……

…… Official Stamp