

Certificate of Continued Disability

Policy numbers

Life assured's name

Address

PLEASE COMPLETE ALL QUESTIONS

DECLARATION

I, the undersigned, declare that:

I reside at the above address. Yes No

I am unable to earn any income due to my disability. Yes No

I am not earning any income from any other sources. Yes No

DISABILITY DETAILS

Physical impairments:

Functions I cannot perform

DOCTOR LAST CONSULTED REGARDING DISABILITY

Name

Telephone number

Signed at

Signature

Date - -

DOCTOR'S DETAILS

THIS SECTION MUST BE COMPLETED

Date the client was last seen for this condition - -

Current symptoms

Current treatment

When was the client last actively able to work? - -

Doctor's name

Qualifications

Telephone number

E-mail

Signature

Date - -