INCOME REPLACEMENT CLAIM FORM

The duly completed Claim Form and Required Supporting Documentation will be delivered by Olé Insurance Group Corp I.I. to Griffin Underwriting Limited as the issuer of the coverage. The validity of the claim will be evaluated, and the payment will be made by them.

We understand that circumstances have occurred to cause you a disability which may give rise to a claim under your Policy. In order to enable us to review your case and ensure payments in good time please supply the following information at your earliest convenience. We are grateful to you for your help and are sorry to hear that these circumstances have arisen.

INFORMATION OF THE INSURED

Name of Insured Policy number: ______________________

______________	______________	______________	______________
First name	Middle name	Last Name	Second Last Name

Identification No.: ____________________ Date of Birth: dd / mm / yy

Address of the Insured: ____

______________	______________	______________	______________
City	State	Country	Postal Code

Occupation: ________________ Email address: ______________________________

Name of current employer: ____________________________________

Address of current employer: ____

______________	______________	______________	______________
City	State	Country	Postal Code

Current gross salary: **USD** ____________________ (monthly)

Salary is defined as “the gross basic monthly salary and other remuneration of constant character (excluding any allowances and bonuses, and excluding any expenses that are reimbursed) received by the Insured Person during the 12 month period immediately preceding the date of the Accident or Sickness giving rise to a loss as supported by a Confidential Financial Statement”.

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LOSS DETAILS

Date when disability first occurred: dd / mm / yy

Date of first consultation of the insured due to loss: dd / mm / yy

Cause of loss: ______

Have you suffered this or any similar condition before? **YES** ◯ **NO** ◯
If YES please supply more information. ______

MEDICAL INFORMATION

Information of the doctor who determined the above.

NAME	SPECIALTY	ADDRESS	EMAIL	PHONE

When was this first diagnosed? dd / mm / yy

When were the symptoms of this illness or accident first manifested? dd / mm / yy

Have you ever suffered from a similar or related illness? **YES** ◯ **NO** ◯

OTHER INSURANCE

Are you now insured against accident or illness and do you have a medical expenses and/or life policy and/or other disability insurance? **YES** ◯ **NO** ◯

If YES, please give details with which insurance company and the coverage amount (indicating if it includes weekly or monthly benefits)? ______

DECLARATION

I understand that the application form on which this coverage was based has information and declarations signed by me. I also understand that such information and declaration will form part of the basis of the settlement of any claim under this coverage. I confirm that the information supplied above is true, and complete and that I have not withheld any material facts.

Signature of the Insured Person: ______________________ Date: mm/ dd / yy

INFORMATION TO SUPPORT YOUR CLAIM

1. Official National ID or passport.
2. Proof of employment, or actively at work under the Occupation declared in the Schedule of Benefits, on the date of Disability;
3. Proof of Annual Salary on the date of Disability. This may include:
Employer payroll statements, taxable income documents, copies of bank statements, evidence of shareholdings, statements from offshore or out of country bank accounts, copies of bank loan applications including bank verification of application, commission earnings received outside of home country;
4. A detailed medical report at the Insured's own expense from the attending physician(s) at the outset, cause and consequences of the Bodily Injury or Sickness as well as the degree and probable duration of the Disability.
5. Utility bill like gas, electricity or water bill and must state your name and address on it. (not older than 3 months)
6. Copies of other current insurance policies, if any.
7. Any other information that may be required to support the claim as requested by the Insurer.