



PERMANENT TOTAL DISABILITY (PTD) CLAIM INTIMATION FORM

DETAILS	TO BE COMPLETED BY THE CLAIMANT / AGENT
Policy Number	
Claim Number	(official use only)
Name of Life Assured	
Name of Claimant	
Address of the Claimant	
Contact Numbers	Residence: Office: Mobile:
Relationship with the Life Assured	
Date & Time of Occurance	
Cause of Permanent Total Disability	<input type="checkbox"/> Medical Reasons <input type="checkbox"/> Accident
If Medical please specify the ailment leading to PTD	
Name & Address of the last Attending Physician to whom the Life Assured was referred	

Claim Requirements

Kindly tick what has been availed

- | | |
|---|--------------------------|
| 1) Completed claim Intimation form (attached) | <input type="checkbox"/> |
| 2) Comprehensive Medical Examiner's Report | <input type="checkbox"/> |
| 3) Police Report for Accidents | <input type="checkbox"/> |
| 3) ID of claimant or equivalent | <input type="checkbox"/> |
| 4) Original Policy document | <input type="checkbox"/> |

I hereby declare and confirm that I am the rightful claimant of this plan and that the details provided above are correct and true to the best of my knowledge. I have not withheld any relevant information and believe that the claimant is the same person as the life assured under the plan issued by **Prudential Assurance Uganda Ltd.**

Date: _____

Signature of Claimant; _____

Name: _____

(Designation): _____