

# Certificate of Continued Disability

Policy numbers

Life assured's name

Address

PLEASE ENSURE ALL QUESTIONS ARE FULLY COMPLETED

## 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

Signature  Date  -  -