OLDMUTUAL

GREENLIGHT

RSA CHILD SEVERE ILLNESS BENEFIT CLAIM FORM

STATEMENT BY CONTRACTING PARTY

Contract number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Please print in block letters using black or blue ink.
This form is issued without admission of liability and must be completed and signed by the contracting party and life covered (if different to the contracting party).

Please email the completed form to claims@oldmutual.com

Intermediary/Admin support:

Name of contact person

Email address and telephone number of contact person

IMPORTANT NOTES

The premium must continue to be paid to avoid plan/benefits ceasing.

Please note that Old Mutual can only consider a claim on receipt of the following documents, marked with the contract number and intermediary code where applicable:

- ☐ Child Severe Illness Benefit Claim Form Statement by contracting party
- ☐ Child Severe Illness Benefit Claim Form Statement by medical specialist
- ☐ A certified copy of the life covered's ID and/or contracting party's ID if different
- ☐ Proof of birth of child, i.e. certified copy of unabridged birth certificate or certified copy of Confirmation of Birth form issued by hospital at the time of birth
- ☐ Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead

There may be further requirements before the claim can be considered.

SECTION 1 DETAILS OF CONTRACTING PARTY

Is the life covered the same person? YES ☐ NO ☐

Title: Mr ☐ Ms ☐ Mrs ☐ Other ☐ Initials

Surname/
Name of institution

Full names/
Contact person

Previous surname
(if applicable)

ID/Passport/Institution
registration number

Date of birth D D M M Y Y Y Y

Income tax number

Residential address/
Physical address of
institution

Postal code

Postal address

Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

SECTION 2 DETAILS OF LIFE COVERED (IF DIFFERENT TO CONTRACTING PARTY)

Title: Mr Ms Mrs Other Initials

Surname

Full names

Previous surname (if applicable)

ID/Passport number Date of birth D D M M Y Y Y Y

Income tax number

Residential address

Postal code

Postal address

Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

SECTION 3 DETAILS OF CHILD

Surname

Full names

ID number Date of birth D D M M Y Y Y Y

Is the child an adopted child of the life covered? YES NO

Name of father

ID number of father

Name of mother

ID number of mother

SECTION 4 BANKING DETAILS OF CONTRACTING PARTY (OR BENEFICIARY, IF DIFFERENT)

Name of bank

Branch name Branch code

Account holder name

Account number ID number of account holder

Account holder relationship: Own account Joint account Type of account: Cheque Savings Transmission

SECTION 5 MEDICAL HISTORY

When was your child's current condition diagnosed? D D M M Y Y Y Y

Who initially diagnosed your child's condition?

Doctor's name	
Contact number	

Please provide the name(s) and address(es) of all medical specialist and hospitals involved in your child's medical care, and referral dates.

Name (medical practitioner/hospital)	Address	Medical condition/procedure	Referral date	Duration

Contract number

SECTION 6 PARTICULARS OF ILLNESS

What condition is being claimed for? Please tick the relevant block.

- ☐ Accidental HIV via a blood transfusion
- ☐ Accidental HIV via an organ transplant
- ☐ Acquired mental retardation
- ☐ AIDS
- ☐ Bacterial meningitis
- ☐ Benign brain tumour
- ☐ Bone marrow failure (including aplastic anaemia)
- ☐ Cancer
- ☐ Cancer benefit enhancer
- ☐ Cardiomyopathy
- ☐ Chronic kidney failure
- ☐ Chronic respiratory failure
- ☐ Coma
- ☐ Heart surgery
- ☐ Heart transplant
- ☐ Hematopoietic stem cell (bone marrow) transplant
- ☐ Juvenile onset recurrent respiratory papillomatosis
- ☐ Kidney transplant
- ☐ Liver transplant
- ☐ Loss of hearing
- ☐ Loss of sight
- ☐ Lung transplant
- ☐ Multiple sclerosis
- ☐ Pancreas transplant
- ☐ Paralysis
- ☐ Spinal cord tumour
- ☐ Stroke
- ☐ Terminal illness
- ☐ Type I diabetes

SECTION 7 DECLARATION BY THE LIFE COVERED AND CONTRACTING PARTY

PROTECTION OF PERSONAL INFORMATION ACT (POPIA) NOTICE

The Old Mutual Group would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that may be suitable to meet your financial needs. Please SMS your ID number to **30994** if you would prefer not to receive such information and/or financial services.

We may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification of personal information
- Claims checks (ASISA Life and Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect your personal information.

You may access your personal information that we hold and may also request us to correct any errors or to delete this information. In certain cases you have the right to object to the processing of your personal information.

You also have the right to complain to the Information Regulator, whose contact details are:

Website	www.justice.gov.za/inforeg/index.html
Contact Number	012 406 4818
Fax	086 500 3351
Email	inforeg@justice.gov.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za

1. I hereby declare that the details provided in this form are true, correct and complete.
2. I declare that the medical condition of the life covered is not directly or indirectly caused by any of the medical conditions excluded in the terms and conditions of the contract.

Signed at (place) _____ on (date) D D M M Y Y Y Y

Signature of contracting party

Signature of life covered (if different to contracting party)

Old Mutual Claim Contact Details:

Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

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Contract number

Old Mutual is a Licensed Financial Services Provider