OLDMUTUAL

GREENLIGHT

RSA CHILD IMPAIRMENT AND CONGENITAL BIRTH DEFECTS BENEFIT CLAIM FORM

STATEMENT BY MEDICAL SPECIALIST

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 medical specialist.

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

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:

1. Child Impairment and Congenital Birth Defects Benefit Claim form Statement by medical specialist.
2. Child Impairment and Congenital Birth Defects Benefit Claim form Statement by contracting party.
3. Please ensure that the supporting documents (e.g. specialist reports and test results) in support of the claim is attached to this claim form.

There may be further requirements before the claim can be considered.
These depend on the Benefit concerned and the cause of impairment.

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 REQUEST TO MEDICAL SPECIALIST, HOSPITAL OR CLINIC

Doctor's name

Address

Postal code

Please complete the Confidential Medical Report overleaf in respect of the disease or disorder for which you have been treating the life covered's child.
I authorise you to disclose to Old Mutual any information you may have concerning the health of my child.
The cost of completing this form and supplying any additional medical information is at the customers own expense.

Signature of contracting party/life covered

SECTION 4 DETAILS OF CHILD

Surname

Full names

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

SECTION 5 MEDICAL HISTORY

When was the child's current condition/birth defect diagnosed (this includes diagnoses made in utero)? D D M M Y Y Y Y

Who initially diagnosed the child's condition/birth defect?

Doctor's name	
Contact number	

Who referred the child to you?

Doctor's name	
Contact number	

Contract number

SECTION 6 DETAILS OF CHILD'S IMPAIRMENT/CONGENITAL BIRTH DEFECT

Please tick relevant block, supply reports as indicated and answer questions in the relevant block.

☐ **Accidental Brain Damage**
- Supply copies of specialist reports confirming the permanent impairment of intellectual capacity as a result of brain damage sustained in an accident
- Supply a copy of neuro-psychological test results

☐ **Anal Atresia**
- Supply copies of specialist reports confirming the diagnosis of anal atresia.
- Has the child undergone a temporary colostomy procedure? YES ☐ NO ☐

☐ **Biliary Atresia**
- Supply copies of specialist reports confirming the diagnosis of biliary atresia, including all imaging investigations

☐ **Cerebral Palsy**
- Supply copies of specialist reports confirming the diagnosis of cerebral palsy

☐ **Cleft Palate**
- Supply copies of specialist reports confirming the diagnosis of a cleft palate

☐ **Clubbed Feet**
- Supply copies of specialist reports confirming the diagnosis of bilateral clubbed feet
- Does the child require surgical intervention? YES ☐ NO ☐
- Does the child require casting/immobilisation of his/her feet? YES ☐ NO ☐

☐ **Congenital Deafness**
- Supply copies of specialist reports confirming the diagnosis of the total and permanent loss of hearing in both ears, including results from a newborn hearing screening programme such as the automated otocoustic emission test or the automated auditory brainstem response test.

☐ **Congenital Heart Disease**
- Supply copies of specialist reports confirming the diagnosis of congenital heart disease
- Does the child require open heart surgery to correct the problem? YES ☐ NO ☐

☐ **Congenital Hip Dislocation**
- Supply copies of specialist reports confirming the diagnosis of congenital bilateral hip dislocations
- Does the child require surgery to correct the problem? YES ☐ NO ☐

☐ **Cystic Fibrosis**
- Supply copies of specialist reports confirming the diagnosis of cystic fibrosis, including a diagnostic sweat test

☐ **Down's Syndrome**
- Supply copies of specialist reports confirming the birth of the life covered's child with Down's syndrome, including chromosome studies
- Confirm if the child has any of the following:
  - Congenital heart disease YES ☐ NO ☐
  - Gastrointestinal congenital abnormalities YES ☐ NO ☐
  - Hearing loss YES ☐ NO ☐
  - Intellectual impairment YES ☐ NO ☐

☐ **Duchenne Syndrome and Congenital Myotonic Dystrophy**
- Supply copies of specialist reports confirming the diagnosis of Duchene Muscular Dystrophy OR Congenital Myotonic Muscular Dystrophy

☐ **Haemophilia**
- Supply copies of specialist reports confirming the diagnosis of haemophilia
- What is the percentage of normal clotting factor in the blood? ☐
- How many blood transfusions are required per month? ☐

☐ **Hypospadias**
- Supply copies of specialist reports confirming the diagnosis of a hypospadias

☐ **Inborn Metabolic Disorders**
- Supply copies of specialist reports confirming the diagnosis of one of the following Inborn Errors of Metabolism: Gaucher's disease; Tay Sachs Disease or Mucopolysaccharidosis
- Please indicate which of the following the child presents with:
  - Organ failure ☐
  - Developmental delay over a 12 month period ☐
  - Documented mental retardation ☐

☐ **Loss of Hearing**
- Supply copies of specialist reports confirming the diagnosis of a total and permanent loss of hearing in both ears

Contract number ☐☐☐☐☐☐☐☐☐☐☐

- Please indicate the child's audiometry results for each ear:
  - Left ear ____ dB
  - Right ear ____ dB

☐ **Loss of Sight**
- Supply copies of specialist reports confirming the diagnosis of a total and permanent loss of sight in both eyes
- Please indicate the child's visual acuity results for each eye:
  - Left eye
  - Right eye

☐ **Loss of Speech**
- Supply copies of specialist reports confirming that the diagnosis of a total and permanent loss of the ability to speak

☐ **Major Burns**
- Supply copies of specialist reports confirming that the child has suffered full thickness, third degree burns
- Please confirm the percentage of total body surface area involved. ____ %

☐ **Neuro-developmental Disorders**
- Please indicate which disorder the child has been diagnosed with:
  - Symptomatic Rett syndrome with a MECP2 mutation ☐
  - Symptomatic fragile X syndrome with a FMR1 mutation ☐
  - Symptomatic tuberous sclerosis with a TSC2 mutation with convulsions or neurological deficit ☐
  - Symptomatic neurofibromatosis with convulsions or neurological tumours ☐
- Supply copies of specialist reports confirming the diagnosis of the above-mentioned neuro-developmental disorder

☐ **Permanent confinement to Bed or Wheelchair**
- Supply copies of specialist reports confirming the diagnosis of a total and permanent confinement to a bed or wheelchair

☐ **Spina Bifida**
- Supply copies of specialist reports confirming the diagnosis of spina bifida

☐ **Terminal Illness**
- Supply copies of medical reports confirming the child's diagnosis of a medical condition, which will result in death within 12 months

☐ **Tracheo-oesophageal Fistula and Oesophageal Atresia**
- Supply copies of specialist reports confirming the diagnosis of a tracheo-oesophageal fistula or oesophageal atresia

SECTION 7 DECLARATION BY MEDICAL SPECIALIST

Initials

Surname

Full names

Practice number

Qualifications

Address

Postal code

Contact number

Fax number Code No.

I certify that I have personally attended to the patient and that all the foregoing statements are correct to the best of my knowledge. I confirm that I will adhere to all the applicable Data Protection legislation.

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

Signature of medical specialist

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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