

GUIDELINES

Please help Old Mutual Group Assurance to assess the claim correctly, by using these guidelines:

1. Complete the application form in detail as it gives us important information
2. Remember to attach a medical report from the treating Specialist, as well as diagnostic test results confirming the condition/illness
3. You are welcome to contact us at 021 509 3911 if you are unsure about any aspect of completing this form

Submit the form electronically, by fax or post:

Email gapdisabilityassessments@oldmutual.com

Fax 021 509 6855

Group Assurance Disability Claims (6J)

Old Mutual

PO Box 1659

Cape Town 8000

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Old Mutual Group may use, share or obtain your personal information (including criminal and/or health information) for the following purposes:

- Underwriting
- Assessment and processing of claims
- Where applicable, credit reference searches or verification, credit scoring and assessment and credit management
- Verification of personal information (including your identity, address and banking details)
- Updating your personal information
- Claims checks (Industry Life and Claims Register(s))
- Tracing beneficiaries
- Tracing you where you are uncontactable
- Prevention and detection of fraud, crime, money laundering (including anti-money laundering screening) or other malpractice
- Market or customer satisfaction research or statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements and in connection with legal proceedings
- 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 agree that Old Mutual may view, search and update your information.

You agree that your medical information may be obtained from and shared with relevant third parties, including reinsurers.

You may access your personal information that we hold and may also, under certain circumstances, 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

General enquiries: enquiries@inforegulator.org.za

Complaints: popiacomplaints@inforegulator.org.za

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

1. DECLARATION AND AUTHORISATION TO PAY BENEFIT
Declaration and authorisation by claimant

Accepting that I am thereby curtailing my right to privacy, but to facilitate the assessment and review of my disability claim under a group policy, I authorise Old Mutual to:

- a) obtain from any medical practitioner, health professional, hospital, employer, insurer or other person who may be in possession of, or later acquire, any information concerning my health, occupation and earnings at their request, and
- b) share this information with other parties, i.e. health professionals, the employer, fund or insurers for the sole purpose of the assessment or review of my disability claim

I understand that Old Mutual needs this information to assess the validity of my disability claim.

Old Mutual will use your information or obtain information about you to verify your identity, for assessment of your disability claim, check claim/medical history on the Life and Claims Register, fraud prevention and detection, market research and statistical analysis, audit and record keeping purposes, and compliance with legal and regulatory requirements.

You may access the personal information that we hold and request us to correct any errors or to delete this information. To view our full privacy notice, please visit our website on oldmutual.co.za.

Signature of claimant	<input type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Name of witness	<input type="text"/>		
Signature of witness	<input type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Declaration by employer

I hereby declare that the above information is true and correct, and that no information has been withheld or omitted.

First name(s)

Surname

Job title

Contact details

Telephone number (Work) Code Number

Fax number Code Number

Signature

Date

2. EMPLOYER DETAILS

1.1 General

Fund name

Employer name

Scheme code

Member's surname

Member's first name(s)

Member's employee number

Date on which member commenced service at company

2.2 Details of contact person at the company

First name(s)

Surname

Job title

Contact details

Telephone number (Work) Code Number

Fax number Code Number

Cellphone number

Email address

2.3 Benefit details

Date Terminal Illness cover commenced

Terminal Illness cover amount at date condition/event was diagnosed/occurred R

Condition for which you are claiming

Effective date of claim

Has a claim for this kind of benefit been submitted in the past?

If "YES", give details (including the condition/event the claim relates to).

Latest annual salary

Effective date of salary

Next company salary review date

3. CLAIMANT DETAILS

3.1 Personal details

First name(s)

Surname

Date of birth

Gender M F

Identity number

Postal address

Contact details

Telephone number (Work)

Code

Number

Fax number

Code

Number

Cellphone number

Email address

3.2 Banking details

Name of payee

Bank name

Branch name

Branch code

Account number

Type of account:

 Cheque Savings Transmission

4. TO BE COMPLETED BY THE ATTENDING DOCTOR

Please note: Payment for this examination and report is for the claimant's account.

4.1 Claimant details

First name(s)

Surname

Date of birth

Gender M F

Identity number

Employer name

A terminal illness is defined by Old Mutual as a medical condition that with reasonable medical certainty will result in the death of the life assured within six months of the date medical evidence to that effect is provided.

Would the definition above be applicable to this claimant?

 Y N

Diagnosis

Date of first visit

Date of last visit

A. Diagnosis

Please indicate the terminal illness from which the claimant is suffering, with the appropriate international staging of the disease, where applicable. To support the claim, please provide us with copies of all tests, investigations and reports in your possession.

B. Present condition

Please provide us with sufficient detail of the claimant's present condition to support that a reasonable assessment of the life expectancy of the claimant is less than six months.

C. Treatment received

Please provide us with information on the treatment that the claimant has received to date for this condition and what future treatment is to be provided.

5. DOCTOR'S DETAILS

I certify that I have personally attended the patient and that all the foregoing statements are correct to the best of my knowledge.

Initials and surname

Qualifications

Practice number

Contract details

Telephone number Code Number

Fax number Code Number

Email address

Signed at this day of 20

Signature

