OLDMUTUAL

GREENLIGHT

RSA BENEFIT CLAIM FORM

CERTIFICATE OF MEDICAL ATTENDANT

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 attendant.

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

1. Completion of this form is required to obtain the life covered's medical history and should be extracted from the records of his/her usual family doctor.
2. Please ensure that the copies of reports and test results are attached to this claim form.
3. The fee for this report (including supporting documentation) will be paid by Old Mutual in accordance with the tariff laid down by the S.A. Medical and Dental Council (code A1401).

SECTION 1 DETAILS OF CLAIMANT

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 2 MEDICAL HISTORY

1. All consultations before D D M M Y Y Y Y

Date	Symptoms	Diagnosis	Treatment

Please ensure that that the above section is completed in full. Attach copies of ALL available reports, blood results, etc.

2. Was the life covered informed of all the diagnoses and the severity thereof? YES ☐ NO ☐

If "YES", please provide date and full details.

3. Has the patient consulted any other medical practitioner or has he/she been hospitalised? YES ☐ NO ☐

If "YES", please state name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s).

Name	Address	Illness	Date	Duration

4. Is the patient a member of a medical aid? YES ☐ NO ☐

If "YES", please provide date and full details.

Name of medical aid	
Member number	

Contract number

5. The name and address of the doctor/hospital/institution the life covered consulted prior to your consultations. YES ☐ NO ☐

Name	
Address	
	Postal code

6. For how long have you been the life covered's doctor?

From D D M M Y Y Y Y To D D M M Y Y Y Y

7. Does the life covered have a history of alcohol or drug abuse? YES ☐ NO ☐

If "YES", please provide full details.

SECTION 3 DECLARATION BY MEDICAL ATTENDANT

I, the undersigned, a registered medical practitioner, certify to the above information in respect of the life covered and understand that the fee for this report (including supporting documentation) will be paid by Old Mutual in accordance with the tariff laid down by the S.A. Medical and Dental Council (code A1401).

Initials

Surname

Full names

Practice number

Qualification

Contact number

Address

Postal code

Please indicated amount based on the tariff of fees R .

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 attendant

DOCTOR'S OFFICIAL STAMP

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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Old Mutual is a Licensed Financial Services Provider