

**MATERNITY/PATERNITY
CLAIM FORM**Contract number

This form must be accurately completed and signed by the owner, insured person and medical practitioner.

Please email the completed form to contactus@oldmutual.com

To be completed by the adviser/admin support person if applicable.

Role: Adviser Admin support person

First name(s)

Surname

Email address

Contact number

Adviser code

IMPORTANT NOTES

We can only consider a claim nine months after the Old Mutual Protect Family Support benefit or GREENLIGHT Maternity benefit start date and when we receive the following documents, marked with the contract number where applicable:

- Maternity/Paternity Claim Form (THIS FORM)
- A certified copy of the insured person's ID and/or owner's ID (if different)
- Death certificate of deceased
- Biological child: A certified copy of the child's unabridged birth certificate
- Adopted child: A certified copy of the adoption agreement
- Stepchild: A certified copy of the marriage certificate confirming the marriage to biological parent/legal guardian of the child
- Proof of bank details (e.g. bank statement not older than three months)

There may be further requirements before the claim can be considered, and this will depend on the type of cover concerned. Please refer to your contract as all the conditions listed below may not be covered by your specific contract.

PART 1 TO BE COMPLETED BY THE OWNER**SECTION 1 OWNER'S DETAILS**

Title: Mr Ms Mrs Other Initials

Surname/Legal entity name

Previous surname (if applicable)

First name(s)

Contact person

Date of birth ID/Passport number

Income tax number

Residential address/
Physical address of
legal entity

Nationality/Country
of birth/Legal entity
country of incorporation

Contact detailsTelephone (Work) Code No. (Home) Code No. Cellphone number Email address **SECTION 2 INSURED PERSON'S DETAILS (IF DIFFERENT TO THE OWNER)**Title: Mr Ms Mrs Other Initials Surname Previous surname (if applicable) First name(s) Contact person Date of birth ID/Passport number Income tax number Residential address Nationality/Country of birth **Contact details**Telephone (Work) Code No. (Home) Code No. Cellphone number Email address **SECTION 3 CHILD'S DETAILS**Surname First name(s) Date of birth ID/Passport number 3.1 Is the child the biological child of the insured person? Yes No

If "Yes", provide a certified copy of the unabridged birth certificate.

3.2 Is the child an adopted child of the insured person? Yes No

If "Yes", provide a copy of the adoption agreement.

3.3 Is the child a stepchild of the insured person? Yes No

If "Yes", supply a copy of the marriage certificate confirming the marriage to biological parent/legal guardian of the child.

Father's full name Father's ID number Mother's full name Mother's ID number Contract number 

SECTION 4 BENEFICIARY'S DETAILS

Title: Mr Ms Mrs Other Initials

Surname/Legal entity name

Previous surname (if applicable)

First name(s)

Contact person

Date of birth ID/Passport number

Income tax number

Residential address/
Physical address of
legal entity

Nationality/Country
of birth/Legal entity
country of incorporation

Contact details

Telephone (Work) Code No. (Home) Code No.

Cellphone number

Email address

SECTION 5 BENEFICIARY'S BANKING DETAILS

Should you be claiming for an income benefit, please indicate on which day of the month you would like to receive the monthly claim payment, should this claim be valid.

Day of month Or last day of month

Bank name

Branch name Branch code

Account holder's full name

Account holder's ID number

Account number

Relationship to account holder: Own account Joint account Account type: Cheque Savings

Payment will only be done by electronic transfer. We don't accept responsibility for delays or other damages because of incorrect information provided.

SECTION 6 OWNER/INSURED PERSON'S DECLARATION

PROTECTION OF PERSONAL INFORMATION

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.

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
- Debt tracing or debt recovery
- 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.

Contract number



You agree that your medical information and the answers to the Health and Lifestyle questionnaire may be shared with relevant third parties (including the adviser involved in this application). If, as a result of your health, a decision is taken to increase premiums, not to cover certain conditions or not to accept the application for cover, you agree to the reasons for this decision being shared with the adviser. You understand that if you do not agree, this application for cover will not be processed.

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:

- 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

I/We hereby declare that the insured person is covered under the above-mentioned benefit(s) and that all the particulars given are true and complete.

Date

Owner's signature

Date

Insured person's signature (if different to owner)

PART 2 TO BE COMPLETED BY MEDICAL PRACTITIONER

MEDICAL PRACTITIONER'S DECLARATION

Was the baby stillborn? Yes No If "Yes", what was the gestation period?

Initials

Surname

First name(s)

Practice number

Qualifications

Physical address

Contact number

Email address


I certify that I have personally attended to the insured person 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.

Date

Medical practitioner's signature

OFFICIAL STAMP

Contact us

 0860 222 274

 contactus@oldmutual.com

 PO Box 4512, Cape Town, 8000, South Africa

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