

**GUIDELINES**

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

1. Compete 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](mailto:gapdisabilityassessments@oldmutual.com); Fax 021 509 6855

Group Assurance: Disability Claims (6J)  
Old Mutual  
PO Box 1659  
Cape Town 8000

**COMPLIANCE WITH THE PROTECTION OF PERSONAL INFORMATION ACT (PPI, POPI)**

Old Mutual SuperFund may collect, use and share your personal information for the following purposes:

- To administer your membership of the Old Mutual SuperFund;
- To provide you with information about offerings that will support and enhance your retirement benefits;
- To provide products or services to you, to carry out the transaction you requested and to maintain our relationship;
- For underwriting purposes;
- To assess and process claims;
- To conduct credit reference searches or verification;
- To confirm and verify your identity, address or banking details;
- To verify that you are an authorised user for security purposes;
- For maintaining the accuracy of your personal information;
- For operational purposes, and where applicable, credit scoring and assessment and credit management;
- For purposes of claim checks (e.g. the Industry Life and Claims Register);
- For the detection and prevention of fraud, crime, money laundering or other malpractice;
- To trace you where you are uncontactable;
- To conduct market or customer satisfaction research or for statistical analysis;
- For audit and record keeping purposes;
- For social responsibility purposes;
- In connection with legal proceedings;
- Sharing information with your employer (its intermediary/broker), your intermediary/broker (when applicable), 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;
- To comply with legal and regulatory requirements or industry codes or when otherwise allowed by law.

You agree that we may view, search and update your information and you further agree we may, where required, process your special personal information (and share this information with relevant third parties) in order to achieve a purpose set out above.

You warrant that when you give us personal information about third parties, this information is accurate and correct, and you have received their permission to share their personal information with us.

You confirm that if you are giving consent for a person under 18 (a minor) you have the required authority to do so.

We may transfer your personal information to another country for processing or storage. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to.

You may access the personal information that we hold about you and may also request us to correct any errors or, under certain circumstances request us to delete this information. In certain circumstances, you have the right to object to the processing of your personal information. To do this, simply contact us at the numbers/addresses listed below and specify what information you would like or if you have any questions about this Notice, please contact us at:

- SuperFund Service Centre: 0860 20 30 40
- [superfund@oldmutual.com](mailto:superfund@oldmutual.com)

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

- [www.justice.gov.za/inforeg/index.html](http://www.justice.gov.za/inforeg/index.html)
- General enquiries: [enquiries@inforegulator.org.za](mailto:enquiries@inforegulator.org.za)

Complaints (complete POPIA/PAIA form 5)

- [paia.complaints@inforegulator.org.za](mailto:paia.complaints@inforegulator.org.za) should your PAIA request be denied or there is no response from a public or private bodies for access to records you may use this email address to lodge a complaint.
- [popiacomplaints@inforegulator.org.za](mailto:popiacomplaints@inforegulator.org.za) - should you feel that your personal information has been violated, you may use this email address to lodge a complaint.

Please visit [www.oldmutual.co.za/corporate/retirement-funds/superfund-privacy-policy](http://www.oldmutual.co.za/corporate/retirement-funds/superfund-privacy-policy) to read the full version of the Fund Member Privacy Notice.

**1. DECLARATION AND AUTHORISATION TO PAY BENEFIT**

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  Date

Name of witness

Signature of witness  Date

**Declaration by employer**

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

Name

Job title

**Contact details**

Telephone  Fax

Email address

Signature  Date

**2. EMPLOYER DETAILS**

**2.1 General**

Fund name

Employer name

Member surname

Member first name(s)

Member's employee number  Date on which member commenced service at company

**2.2 Details of contact person at the company**

Name and surname

Job title

**Contact details**

Work  Fax

Cellphone number

Email address

**2.3 Benefit details**

Date Lifestyle cover commenced

Lifestyle cover amount at date condition/event was diagnosed/occurred

Has a claim for this kind of benefit (Lifestyle cover) been submitted in the past?

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

**3. CLAIMANT DETAILS**

**3.1 Personal details**

Surname  Gender: Male  Female

First name(s)

Date of birth  Identity number

Postal address

Postal code

**Contact details**

Telephone (work)  Fax

Cellphone number

Email address

**3.2 Banking details**

Account holder's name

Bank name

Branch name

Branch code

Account number

Account type: Cheque

Savings

Transmission

**3.3 Claim event**

a) What condition is being claimed for?

Cancer

Heart attack

Stroke

Paralysis

Loss of limbs

Loss of hearing

Loss of sight

b) When did it occur?

**3.4 Please provide names(s) and address(es) of all the medical practitioner(s) and hospital(s) involved, and referral date(s).**

Name	Address	Illness	Date	Duration

**4. LIFESTYLE COVER MEDICAL QUESTIONNAIRE**

To be completed by the treating medical specialist.

**4.1 General**

- To determine whether a claimant qualifies for a benefit, Old Mutual requires comprehensive, updated medical information
- The claimant's treating specialist should supply this information
- The report should be supported by the appropriate test results
- The claimant is responsible for the cost of this examination and report

**4.2 Claimant details**

Surname

Gender: Male

Female

First name(s)

Date of birth

Identity number

Employer name

**4.3 Medical History**

What is your diagnosis/es? Please provide the staging/classification of the medical condition.

Please list the special investigations that were done to confirm the diagnosis. Attach copies of reports that confirm the diagnosis, e.g. X-ray and/or special investigations.

Please state the date that the claimant was first diagnosed with the condition he/she is claiming for.

D	D	M	M	Y	Y	Y	Y
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What are the current complaints and symptoms?

Please describe your clinical findings.

In the case of paralysis, loss of sight and loss of hearing, do you consider the claimant's condition total, permanent and irreversible?

Yes  No

If "Yes", please elaborate.

**4.4 Treatment**

Describe the current and past treatment prescribed to the claimant:

- All medication used, including dosages, duration and effectiveness
- All admissions to hospital, including reason, dates and duration
- Other health professional input, e.g. physiotherapy

**Past treatment**

**Present treatment**

What future health management is planned or considered ideal?

Other comments or information

**4.5 Reporting doctor**

Surname	<input type="text"/>		
First name(s)	<input type="text"/>		
Speciality	Practice number	<input type="text"/>	
Name of clinic/ hospital	<input type="text"/>		
Telephone		Fax	<input type="text"/>
Cellphone number	<input type="text"/>		
Email address	<input type="text"/>		
Doctor's signature	<input type="text"/>		
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Thank you for your assistance.**  
**We may need to contact you telephonically to discuss this specific case.**

