OLDMUTUAL

GROUP ASSURANCE
APPLICATION FOR DISMEMBERMENT BENEFITS

Insurance Contract underwritten by Old Mutual

APPLICATION INFORMATION

We look forward to assisting you and your employee through this difficult time.

GUIDELINES FOR COMPLETING THIS FORM

1. We can process the employee's claim quicker if the application form is filled in with all the details of the claim
2. Print, stamp and sign the form if you are completing it electronically, then scan and email it to us
3. Please send us the claim within 12 months of the employee's date of dismemberment. If the claim is sent after this time, it may be declined due to late submission
4. Do you have all the necessary documents to submit this application? Use the checklists below to assist you

Documents that we always need to submit a claim	✓
The completed application form	
Medical questionnaire completed by the treating medical practitioner	
Copy of the employee's identity document (and marriage certificate if the employee's surname has changed)	
Employee's payslip at the date of the incident/dismemberment event	
Employer banking details on the bank letterhead	

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/

SEND THE COMPLETED DOCUMENTS TO US:

Our website **oldmutual.co.za/GAPforms** has useful information and guides to assist you through the claims process. You may also call our HR 911 helpline on 021 509 3911 for any assistance with the claims process.
The completed forms should be returned to Old Mutual Group Assurance, and can be sent to any of the contact details below:

Email gapdisabilityassessments@oldmutual.com
Fax 021 509 6855

Post Old Mutual Group Assurance Claims (6J)
PO Box 1659
Cape Town 8000
South Africa.

GUIDELINES FOR THE EMPLOYER

1. If you provide us with complete and accurate information, we are better able to pay valid claims
2. Are you in an officially recognised position at the employer in order to sign these forms? Please complete the employer declaration

DECLARATION

I, _____ the undersigned, in my capacity as _____ and duly authorised to make this declaration as the employer, hereby declare that the information I provide in this claim is true and correct, and that no information is omitted or withheld.

I indemnify Old Mutual Group Assurance against any claim that may arise from any incorrect information provided in this form.

Full name

Telephone number

Email

Signature

Date D D M M Y Y Y Y

1 TO BE COMPLETED BY THE EMPLOYER

1.1 Scheme details

Scheme name

Employer name

Contact person

Designation

Telephone number Cellphone

Email

Physical address

Postal code

1.2 You are submitting the claim for:

Employee's first name(s)

Employee's Surname

Employee's ID number

Employee's date of birth D D M M Y Y Y Y

Employee number

Gender M F

Employee's job title

Date dismemberment cover commenced D D M M Y Y Y Y

Has a previous claim for this benefit been submitted? Yes No

If "Yes", tell us about it including details of the event the claim related to.

Annual salary at date of event R

Effective date of salary D D M M Y Y Y Y

Next company salary review date D D M M Y Y Y Y

2 TO BE COMPLETED BY THE EMPLOYEE

2.1 Your contact details

Telephone number | Cellphone

Personal email

Physical address

Postal code

2.2 Your banking details

Bank name

Branch code | Account number

Type of account: Cheque | Savings | Transmission

2.3 Your medical history

Treatment

Please describe the treatment of the claimant.

Medication used	Dosages	Duration	Effectiveness

Admissions to hospital: duration, reason for admission, and treatment.

Date of admissions to hospital	Date of discharge	Reason for admission	Treatment

2.4 Details of dismemberment

Details of the accident or Incident that led to the dismemberment of condition.

Date of the accident or incident D D M M Y Y Y Y

Details of the dismemberment or condition being claimed for.

Date of dismemberment D D M M Y Y Y Y

3 TO BE COMPLETED BY THE EMPLOYEE

If you are unable to sign this form, a next of kin can sign on your behalf and can send us an affidavit confirming the relationship and the reason that you are unable to sign the application form.

We commit to keeping your personal information safe. Your accurate and truthful answers will mean that our product can continue to pay the correct claims and protect you and your family.

You declare and authorise us to obtain and share personal health information:

DECLARATION

I, _____, declare that the information provided by me is true and correct, and that I have provided complete answers.

AUTHORISATION

I, _____, expressly consent and authorise Old Mutual:

a) to obtain from any medical practitioner, health professional, hospital, ASISA Life and Claims register, employer, insurer, medical scheme and any other person who or institution which may be in possession of, or later acquire, any information concerning my health, occupation; earnings and insurance cover, and

b) to share this information with other parties, health professionals (including employee wellness programmes), the employer, fund, ombudsman, legal representatives or insurers if necessary, for the purpose of the assessment or review of my disability claim and for return to work rehabilitation purposes.

I agree that Old Mutual may use the personal information provided to them in order to verify my identity and check the validity of my claim and to detect and prevent fraud.

I agree that Old Mutual may investigate my claim fully and use my personal information, including information found in the public domain, in order to verify my identity and check the validity of my claim and to detect and prevent fraud.

I agree that Old Mutual may further use and keep my personal information for historical, statistical, compliance with legal or regulatory requirements and for research purposes, subject to the provisions in the Protection of Personal Information Act 4 of 2013.

I understand that my right to privacy is curtailed to the extent permitted by me in this authorisation. I understand that Old Mutual needs this information to facilitate the assessment and review of my claim under a group policy.

INDEMNITY

I indemnify Old Mutual South Africa and any entity that forms part of the Old Mutual Group of companies, including but not limited to any director, employee or agent of these entities and hold them harmless against any claim, loss or damage arising as a result of:

a) a breach of my personal information (including information relating to my health, occupation and earnings) by any medical practitioner, health professional, my employer, fund or insurer sent to them by Old Mutual with my consent for the purposes of assessment, review or for return to work rehabilitation purposes in relation to my disability claim

b) their identification, assessment and recommendation concerning the treatment I receive from Old Mutual in order to assist me with my rehabilitation;

c) the medical evaluation, advice, and treatment I receive from any medical practitioner or health professional Old Mutual has referred me to

d) Incorrect, inaccurate or insufficient medical information provided to us which we have in turn passed to any medical practitioner or health professional for evaluation, advice or treatment relating to my disability

Your full name

Identity number

Date D D M M Y Y Y Y

Your signature

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