OLDMUTUAL

GROUP ASSURANCE
CRITICAL INCIDENTS CLAIM FORM

Insurance Contract underwritten by Old Mutual

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
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:

a) to 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) to 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 D D M M Y Y Y Y

Name of witness _____

Signature of witness _____ Date D D M M Y Y Y 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

Fax

Email address

Signed at | this | day of | 20

Signature

2. EMPLOYER DETAILS

2.1 General

Fund name

Employer name

Member's surname

Member's first name(s)

Member's employee number

Date on which member commenced service at company D D M M Y Y Y Y

2.2 Details of contact person at the company

First name(s)

Surname

Job title

Contact details

Telephone number (Work)

Fax number

Cellphone number

Email address

2.3 Benefit details

Date Critical Incidents cover commenced D D M M Y Y Y Y

Critical Incidents cover amount at date condition/event was diagnosed/occurred R

Has a claim for this kind of benefit (dread disease) been submitted in the past? Y N

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

3. CLAIMANT DETAILS

3.1 Personal details

First name(s)

Surname

Date of birth D D M M Y Y Y Y Gender M F

Identity number

Postal address

Postal code

Contact details

Telephone number (Work)

Fax 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. MEDICAL HISTORY

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

Name	Address	Illness	Date	Duration

5. PARTICULARS OF ILLNESS

What illness/condition is being claimed for?

When was the illness/condition diagnosed? D D M M Y Y Y Y

6. CRITICAL INCIDENTS CLAIMS MEDICAL QUESTIONNAIRE

To be completed by the treating medical specialist.

6.1 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

6.2 Claimant details

First name(s)

Surname

Date of birth D D M M Y Y Y Y Gender M F

Identity number

Employer name

6.3 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.

- In the case of kidney failure, are both kidneys affected? D D M M Y Y Y Y
- In the case of a surgical procedure, the date of the event D D M M Y Y Y Y
- In the case of a transplant, the date of the transplant or the date that the claimant was first put on the official transplant list D D M M Y Y Y Y

What are the current complaints and symptoms?

How long have these symptoms been present?

Please describe your clinical findings.

In the case of a physical impairment, do you consider the claimant's condition total, permanent and irreversible? Yes ☐ No ☐

If "Yes", please elaborate.

In the case of a physical impairment, please comment on functional limitations as a result of the medical condition.

6.4 Treatment

Describe the current and past treatment prescribed to the claimant:

- All medication used, including dosages, duration and effectiveness
- In the case of a surgical procedure, the date of the event
- Other health professional input, e.g. physiotherapy

Past treatment

Present treatment

Do you consider this treatment optimal?

Is the claimant compliant with the treatment?

What future health management is planned or considered ideal?

Other comments or information

6.5 Reporting doctor

First name(s)	
Surname	
Speciality	
Practice number	
Name of clinic/ hospital	
Telephone number	
Fax number	
Cellphone number	
Email address	
Signature of doctor	
Date	D D M M Y Y Y Y

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

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