GROUP ASSURANCE
LIFESTYLE COVER 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 Fund will provide you with ongoing communication and information about Fund related products or services that may be suitable to meet your Fund related financial needs.

We may use your information or obtain information about you for the following purposes:
- Underwriting in respect of Fund risk benefits
- Assessment and processing of Fund benefit claims
- Member communication
- Verification of personal information
- Claims checks (industry Life and Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verifying your identity
- Updating your personal information
- Sharing information with service providers we engage to process such information on our behalf or who render services to the Fund.

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 may access your personal information that we hold and may also 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:

Web www.justice.gov.za/inforeg/index.html
Tel 012 406 4818
Fax 086 500 3351
Email inforeg@justice.gov.za

Please visit our Secure Services website on secure.dcc.oldmutual.co.za/omlogin.aspx and access 'Self Service' under 'My Portfolio' to exercise your preferences.

To view our full privacy notice, visit oldmutual.co.za/corporate/retirement-funds/superfund-privacy-policy

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 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.

Name

Job title

Contact details

Telephone | Fax

Email address

Signature | Date D D M M Y Y Y Y

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

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

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

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 D D M M Y Y Y Y | 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? D D M M Y Y Y Y

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 D D M M Y Y Y Y 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

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			
First name(s)			
Speciality		Practice number	
Name of clinic/ hospital			
Telephone		Fax	
Cellphone number			
Email address			
Doctor's signature			
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.

OLDMUTUAL