

**GUIDELINES**

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

1. Complete 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

**PROTECTION OF PERSONAL INFORMATION DISCLOSURE**

The personal information received by Old Mutual in accordance with this contract will be used, as and when appropriate, for the following purposes:

- Underwriting
- Assessment and processing of claims
- Claims checks (Life and Claims Register)
- Fraud prevention and detection
- Tracing beneficiaries
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verification of the personal information provided

Personal Information will be de-identified when used for market research and statistical analysis.

When Old Mutual engages service providers to process personal information on its behalf or to render services to it, Old Mutual may share some personal information with these service providers, subject to confidentiality agreements being in place between Old Mutual and such service providers. Should these service providers be abroad, Old Mutual will not share the personal information with them unless it is satisfied that adequate security measures are in place to protect the personal information.

The Policyholder is advised and encouraged to inform all members/lives assured that Old Mutual holds and is processing their personal information for the purposes noted above. The Policyholder or a member/life assured may access the personal information relating to him or her and, subject to the provisions this contract may request the correction of any errors or the deletion of this information. In certain cases the Policyholder and members/lives assured have the right to object to the processing of their personal information.

The Policyholder or members/lives assured have the right to complain to the Information Regulator, whose contact details are:

**Website** [justice.gov.za/inforeg/index.html](http://justice.gov.za/inforeg/index.html)  
**Tel** 012 406 4818  
**Fax** 086 500 3351  
**Email** [inforeg@justice.gov.za](mailto:inforeg@justice.gov.za)

Old Mutual's full privacy notice can be viewed at [oldmutual.com/privacy-notice](http://oldmutual.com/privacy-notice)

**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](http://oldmutual.co.za).

Signature of claimant

Date

D	D	M	M	Y	Y	Y	Y
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Name of witness

Signature of witness

Date

D	D	M	M	Y	Y	Y	Y
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**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

**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

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?

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

Annual salary at date of event  R

Effective date of salary

Next company salary review date

### 3. CLAIMANT DETAILS

#### 3.1 Personal details

First name(s)

Surname

Date of birth  Gender

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?

## 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)	<input type="text"/>
Surname	<input type="text"/>
Date of birth	<input type="text" value="D D M M Y Y Y Y"/> Gender <input type="text" value="M F"/>
Identity number	<input type="text"/>
Employer name	<input type="text"/>

### 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?
- In the case of a surgical procedure, the date of the event
- 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

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

