OLDMUTUAL

GROUP ASSURANCE
TERMINAL ILLNESS 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 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
Tel 012 406 4818
Fax 086 500 3351
Email inforeg@justice.gov.za

Old Mutual's full privacy notice can be viewed at 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 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 Rgister, 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

Work Code Number

Fax Code Number

Signature

Date D D M M Y Y Y Y

2. EMPLOYER DETAILS

1.1 General

Fund name

Employer name

Scheme code

Member surname

Member first name

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 Code Number

Fax Code Number

Cellphone number

Email address

2.3 Benefit details

Date Terminal Illness cover commenced D D M M Y Y Y Y

Terminal Illness cover amount at date condition/event was diagnosed/occurred R

Condition for which you are claiming

Effective date of claim D D M M Y Y Y Y

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

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

Latest annual salary 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

Name

Surname

Date of birth D D M M Y Y Y Y

Gender M F

Identity number

Postal address

Postal code

Contact details

Work Code Number

Fax Code Number

Cellphone number

Email address

3.2 Banking details

Name of payee

Name of bank

Name of branch

Branch code

Account number

Type of account: Cheque Savings Transmission

4. TO BE COMPLETED BY THE ATTENDING DOCTOR

Please note: Payment for this examination and report is for the claimant's account.

4.1 Claimant details

Name

Surname

Date of birth D D M M Y Y Y Y

Gender M F

Identity number

Employer name

A terminal illness is defined by Old Mutual as a medical condition that with reasonable medical certainty will result in the death of the life assured within six months of the date medical evidence to that effect is provided.

Would the definition above be applicable to this claimant? Y N

Diagnosis

Date of first visit D D M M Y Y Y Y

Date of last visit D D M M Y Y Y Y

A. Diagnosis

Please indicate the terminal illness from which the claimant is suffering, with the appropriate international staging of the disease, where applicable. To support the claim, please provide us with copies of all tests, investigations and reports in your possession.

B. Present condition

Please provide us with sufficient detail of the claimant's present condition to support that a reasonable assessment of the life expectancy of the claimant is less than six months.

C. Treatment received

Please provide us with information on the treatment that the claimant has received to date for this condition and what future treatment is to be provided.

5. DOCTOR'S DETAILS

I certify that I have personally attended the patient and that all the foregoing statements are correct to the best of my knowledge.

Initials and surname

Qualifications

Practice number

Contract details

Telephone Code Number

Fax Code Number

Email address

Signed at this day of 20

Signature

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Old Mutual is a Licensed Financial Services Provider