GREENLIGHT

RSA

SICKNESS INCOME BENEFIT CLAIM FORM

Contract number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Please print in block letters using black or blue ink.
This form is issued without admission of liability and must be completed and signed by the contracting party, life covered (if different to the contracting party) and the medical practitioner.

Please email the completed form to claims@oldmutual.com

Intermediary/Admin support:

Name of contact person

Email address and telephone number of contact person

IMPORTANT NOTES

The premium must continue to be paid as contractually stipulated to avoid plan/benefits ceasing.

Please note that Old Mutual can only consider a claim on receipt of the following documents, marked with the contract number and intermediary code where applicable:

- ☐ Sickness Income Benefit Claim Form with all questions answered in full.
- ☐ Hospital discharge record (in the event of hospitalisation).
- ☐ Legible copies of medical certificate/sick note (if available).
- ☐ A certified copy of the life covered's ID and/or contracting party ID if different.
- ☐ Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead.

There may be further requirements before the claim can be considered.

Guidelines on submission of a claim:

PART 1 Must be completed and signed by the claimant/contracting party where appropriate.
PART 2 Must be completed and signed by the claimant's attending medical practitioner.

PART 1 TO BE COMPLETED BY THE CLAIMANT

SECTION 1 DETAILS OF CONTRACTING PARTY

Is the life covered the same person as the contracting party? YES ☐ NO ☐

Title: Mr ☐ Ms ☐ Mrs ☐ Other Initials

Surname/
Name of institution

Full names/
Contact person

Previous surname
(if applicable)

ID/Passport/Institution registration number

Date of birth D D M M Y Y Y Y

Income tax number

Residential address/
Physical address of institution

Postal code

Postal address

Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

Old Mutual Life Assurance Company (South Africa) Limited. Reg No: 1999/004643/06

SECTION 2 DETAILS OF LIFE COVERED (IF DIFFERENT TO CONTRACTING PARTY)

Title: Mr Ms Mrs Other Initials

Surname

Full names

Previous surname (if applicable)

ID/Passport number

Date of birth D D M M Y Y Y Y

Income tax number

Residential address

Postal code

Postal address

Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

SECTION 3 BANKING DETAILS OF CONTRACTING PARTY (OR BENEFICIARY, IF DIFFERENT)

Name of bank

Branch name

Branch code

Account holder name

Account number

ID number of account holder

Account holder relationship: Own account Joint account

Type of account: Cheque Savings Transmission

SECTION 4 DETAILS OF TREATMENT

4.1 On what date did you first consult a medical practitioner in connection with your current medical condition? D D M M Y Y Y Y

Please provide details.

Name (medical practitioner/hospital)	Address	Medical condition/procedure	Referral date	Duration

4.2 Have you previously received any medical, chiropractic or psychological attention, treatment or medication? YES NO
(Excluding colds, influenza and general children's ailments)

If "Yes", please provide details.

Name (medical practitioner/hospital)	Address	Medical condition/procedure	Occurrence date	Duration

4.3 Are you a member of a medical aid? YES NO

Name of medical aid		Member number	
Name of main member			

Contract number

SECTION 5 DETAILS OF OCCUPATION

5.1 What is your current occupation?

5.2 Please give a complete description of your occupation and daily duties.

(a) Administrative ___ % (b) Manual ___ % (c) Supervisory ___ % (d) Travelling ___ %

5.3 Since when have you been practicing this occupation? D D M M Y Y Y Y

5.4 When do you expect to no longer be booked off?

- Full capacity D D M M Y Y Y Y
- Partial capacity D D M M Y Y Y Y

5.5 If applicable, were you booked off for the sickness/injury during a period of:

- Annual leave
- Family responsibility leave
- Maternity leave
- Special consideration includes the time when the life covered:
  - is not practicing his/her occupation,
  - has been granted leave as an extension to approved leave by his/her employer, or
  - has been granted unpaid leave by his/her employer.
- Not applicable

Please provide start date of leave. D D M M Y Y Y Y

SECTION 6 INCOME INFORMATION

Please provide full details of your earnings in the **12 months prior** to the commencement of your medical condition. Also provide details of any fluctuating income (commission, bonuses, etc.) received in the **three years prior** to the commencement of your medical condition.

Other sources of employment related income

Additional requirements may be requested at Old Mutual's discretion, e.g. salary slips, tax returns.

SECTION 7 ADDITIONAL INFORMATION

7.1 Have you travelled or resided outside the RSA in the past 12 months? YES NO

If "Yes", please provide details.

Country visited	
Reason for visit	

Date of arrival D D M M Y Y Y Y Date of return D D M M Y Y Y Y

7.2 Do you participate in any risky activities/hobbies or sport? YES NO

If "Yes", please specify.

Contract number

SECTION 8 DECLARATION BY THE LIFE COVERED AND CONTRACTING PARTY

PROTECTION OF PERSONAL INFORMATION ACT (POPIA) NOTICE

The Old Mutual Group would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that may be suitable to meet your financial needs. Please SMS your ID number to **30994** if you would prefer not to receive such information and/or financial services.

We may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification of personal information
- Claims checks (ASISA Life & Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit & record keeping purposes
- Compliance with legal & regulatory requirements
- Verifying your identity
- 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 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:

Website	www.justice.gov.za/inforeg/index.html
Contact Number	012 406 4818
Fax	086 500 3351
Email	inforeg@justice.gov.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za

1. I hereby declare that the details provided in this form are true, correct and complete.
2. I declare that the medical condition that led to the sickness of the life covered is not directly or indirectly caused by any of the medical conditions excluded in the terms and conditions of the contract.

Signed at (place) ______________________ on (date) D D M M Y Y Y Y

Signature of contracting party

Signature of life covered (if different to the contracting party)

Old Mutual Claim Contact Details:

Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

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PART 2 TO BE COMPLETED BY MEDICAL PRACTITIONER

SECTION 1 DECLARATION BY MEDICAL PRACTITIONER FOR A SICKNESS INCOME BENEFIT CLAIM

Important:

1) Any cost involved to complete this form is the responsibility of the claimant.
2) An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.

Please supply the following additional completed documents:

1) Copies of specialist reports (if applicable).

SECTION 2 DETAILS OF CLAIMANT

Surname

Full names

ID number

Date of birth D D M M Y Y Y Y

SECTION 3 NATURE OF CLAIM AND PARTICULARS OF CONSULTATIONS

3.1 **Referring medical practitioner:**

Initials Surname

Telephone Code No.

3.2 The claimant first consulted me for this current condition on D D M M Y Y Y Y

Follow-up consultation dates: 1st D D M M Y Y Y Y

2nd D D M M Y Y Y Y

3rd D D M M Y Y Y Y

3.3 ☐ Primary diagnosis Diagnostic code (ICD -10)

☐ Secondary diagnosis Diagnostic code (ICD -10)

3.4 Describe the details of the sickness/injury.

Date the sickness first started/injury occurred D D M M Y Y Y Y

3.5 Was the claimant hospitalised as a result of the current sickness/injury? YES ☐ NO ☐

If "Yes", please provide the following details.

Date admitted	**Date discharged**	**Hospital details**	**Patient number**

3.6 Was any surgery performed? YES ☐ NO ☐

If "Yes", please specify the type of operation/procedure.

Date of operation D D M M Y Y Y Y

3.7 Is the claimant currently booked off? YES ☐ NO ☐

If "Yes", please specify if this was in their:

☐ Full capacity From D D M M Y Y Y Y To D D M M Y Y Y Y

☐ Partial capacity From D D M M Y Y Y Y To D D M M Y Y Y Y

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3.8 Were there any complications/reasons resulting in the claimant being booked off for a period longer than reasonably expected? (Please include copies of specialists reports and/or test results if applicable) YES ☐ NO ☐

If "Yes", please provide details.

SECTION 4 PARTICULARS OF MEDICAL PRACTITIONER

Surname

Full names

Medical Board registration number

Practice number

Qualification

Contact number

Email address

Signed at (place) on (date) D D M M Y Y Y Y

- I certify that I have personally attended to the patient and that all the foregoing statements are correct to the best of my knowledge.
- I confirm that I will adhere to all the applicable Data Protection legislation.

Signature of medical practitioner

MEDICAL PRACTICE/ HOSPITAL STAMP

Old Mutual Claim Contact Details:

Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

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Old Mutual is a Licensed Financial Services Provider