OLDMUTUAL

NAM

Plan number (e.g. 12345678)

Intermediary code (e.g. PFA: A12345678 BROKER: 78870)

GREENLIGHT
BENEFIT CLAIM FORM
CERTIFICATE OF MEDICAL ATTENDANT

Please print in block letters using black or blue ink.

FOR OFFICE USE ONLY
This claim form has been checked for completeness and accuracy by:
Name of Sales Co-ordinator/ Admin. Support person/Intermediary

Email & Tel. no of Sales Co-ordinator/ Admin. Support person/Intermediary

This form is issued without admission of liability and must be signed by the Contracting Party and Life Covered (if different to the Contracting Party) and forwarded to:

GREENLIGHT Client Service Centre
PO Box 165
Windhoek
Namibia
Fax: 061 246 795

SECTION 1 DETAILS OF LIFE COVERED

Title: Mr Ms Mrs Other Initials

Surname/ Name of institution

First names/ Contact person

Previous surname (if applicable)

ID number/Institution registration number

Passport number (where no Namibian ID number is available)

Expiry date of passport D D M M Y Y Y Y

Country of issue of passport

Date of birth D D M M Y Y Y Y Age next birthday Gender: Male Female

Income tax number Are you a Namibian resident? YES NO

Residential address/ Physical address of institution Postal code

Postal address Postal code

Telephone numbers

(W) Code No. (H) Code No.

Fax: Code No. Cellphone number

Email address

Marital status: Single Married Divorced Widowed Correspondence language: English Afrikaans

Completion of this form is required to obtain the Life Covered's medical history and should be extracted from the records of his/her usual family doctor.

SECTION 2 MEDICAL HISTORY

2.1 ALL CONSULTATIONS BEFORE D D M M Y Y Y Y

Date	Symptoms	Diagnosis	Treatment

Please ensure that the above section is completed in full. Attach copies of all available reports, blood results, etc.

2.2 Was the Life Covered informed of all the diagnoses and the severity thereof? YES ☐ NO ☐

If "YES", please provide date and full details.

2.3 Has the patient consulted any other medical practitioner or has he/she been hospitalised? YES ☐ NO ☐

If "YES", please state name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s).

Name	Address	Illness	Date	Duration

2.4 Is the patient a member of a medical aid? YES ☐ NO ☐

Name of medical aid	
Member number	
Name of main member	

2.5 The name and address of the doctor/hospital/institution the Life Covered consulted prior to your consultations.

Name	
Address	
	Postal code

2.6 For how long have you been the Life Covered's doctor?

From D D M M Y Y Y Y To D D M M Y Y Y Y

2.7 Does the Life Covered have a history of alcohol or drug abuse? YES ☐ NO ☐

If "YES", please provide full details.

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2.8 (a) Is there any reason to believe that the assured's estate of health is in any way due to or has arisen directly or indirectly, entirely or partially, from AIDS or HIV infection? YES ☐ NO ☐

If "YES", please provide full details.

(b) Has the assured ever been tsted for HIV antibodies? YES ☐ NO ☐

If "YES", when? D D M M Y Y Y Y

By whom?

What was the results?

(c) If HIV-positive":

Date of diagnosis D D M M Y Y Y Y

When was the assured informed of the "HIV-positive: diagnosis? D D M M Y Y Y Y

2.9 Have you travelled or resided outside the Republic of Namibia in the past 12 months? YES ☐ NO ☐

If "YES", please provide full details including dates.

SECTION 3 DECLARATION BY MEDICAL ATTENDANT

I, the undersigned, a registered medical practitioner, certify to the above information in respect of the Life Covered and understand that the fee for this report will be paid by Old Mutual in accordance with the tariff agreed by LAAN and the Medical Association of Namibia.

Signed at ____ on this ____ day of ____ 20

Signature of medical attendant

OFFICIAL STAMP

Initials ____ Surname ____

Practice number

Qualifications

Address

Postal code

Telephone Code ____ No. ____

Fax Code ____ No. ____

Please indicated amount based on the tariff of fees N$ ____

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