GREENLIGHT

NAM SEVERE ILLNESS BENEFIT
CLAIM FORM
Statement by Contracting Party

GREENLIGHT contract number (e.g. 12345678)

Intermediary code (e.g. PFA: A123456; BROKER: 78870)

Please complete in BLOCK LETTERS using black or blue ink.

This form needs to be completed and signed by the person instituting the claim and is issued without admission of liability.
Please fax or post the completed claim form to the number or address that applies to the benefits included in the claim.

FOR OFFICE USE ONLY
This claim form has been checked for completeness and accuracy by.

Name of contact person submitting the form	
Telephone number of person submitting the form	
Email address of person submitting the form	

GREENLIGHT BENEFITS

Fax number	061 225 261
Telephone number	061 223 189
Email	namibia@oldmutual.com
Address	Mutual Tower, 223 Independence Avenue, Windhoek, Namibia PO Box 165, Windhoek, Namibia
Servicing hours	08:00 to 18:00 Monday to Friday Closed on Saturdays

IMPORTANT NOTES

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

1. **Claim form (Severe Illness Benefit Claim form Statement by Contracting Party) with all questions answered in full.**
2. **Fully completed Severe Illness Benefit Claim Form Statement by Medical Specialist.**
3. **A certified copy of the Life Covered's ID.**
4. **Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead.**
5. **Please continue paying your monthly contributions to avoid benefits ceasing.**

There may be further requirements before the claim can be admitted. These depend on the Benefit concerned and the cause of illness. Please contact the Claims Call Centre at 061 239 548 for more details.

SECTION 1 DETAILS OF CONTRACTING PARTY

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)

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 address

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

The Financial Services Charter requires life insurance companies to report on the racial spread of their client bases. Please assist us to fulfil our obligations under the Charter by indicating to us the race group to which you feel you belong. This information will be used only for determining (and reporting on) the racial spread of our client base.

Race: Black ☐ Indian ☐ Coloured ☐ White ☐

Old Mutual Life Assurance Company (Namibia) Limited. Reg. no: 97/081

OM Severe Illness Benefit Claim Form CP omms 08.2014 L7433 NAM

SECTION 2 DETAILS OF BENEFICIARY

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)

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 address

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

The Financial Services Charter requires life insurance companies to report on the racial spread of their client bases. Please assist us to fulfil our obligations under the Charter by indicating to us the race group to which you feel you belong. This information will be used only for determining (and reporting on) the racial spread of our client base.

Race: Black ☐ Indian ☐ Coloured ☐ White ☐

SECTION 3 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)

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 address

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

The Financial Services Charter requires life insurance companies to report on the racial spread of their client bases. Please assist us to fulfil our obligations under the Charter by indicating to us the race group to which you feel you belong. This information will be used only for determining (and reporting on) the racial spread of our client base.

Race: Black ☐ Indian ☐ Coloured ☐ White ☐

Contract number

SECTION 4 BANKING DETAILS OF CONTRACTING PARTY

Name of bank

Branch name Branch code

Name of accountholder

Account number Account type Cheque Savings Transmission

Accountholder relationship Own account

SECTION 5 MEDICAL HISTORY

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

Please provide the name(s) and address(es) of all medical practitioners and hospitals involved, and referral date(s).

Name	Address	Illness	Date	Duration

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

If "Yes", please state the nature of the illness and give names and addresses of the doctors and hospitals consulted, including the dates of occurrence.

Name	Address	Illness	Date	Duration

Are you a member of a medical aid? Yes No

Name of medical aid	
Member number	
Name of main member	

SECTION 6 PARTICULARS OF ILLNESS

What illness is being claimed for? Please tick the relevant block.
(You are advised to refer to your contract, as all the conditions listed below may not be covered by your specific contract.)

- Accidental brain injury
- Accidental HIV for medical, dental or nurse practitioners
- Accidental HIV via a blood transfusion
- Accidental HIV via a road traffic accident
- Accidental HIV via an organ transplant
- Accidental HIV via violent crime, rape or indecent assault
- Acquired mental retardation
- Activities of daily living
- Advanced rheumatoid arthritis
- Advanced skin cancer: Basal cell carcinoma
- Advanced skin cancer: Squamous cell carcinoma
- AIDS
- Amputation of limb
- Angioplasty and/or stenting
- Aortic aneurysm
- Aortic surgery
- Bacterial meningitis
- Benign brain tumour
- Bilateral carotid artery surgery
- Bone marrow failure (including severe aplastic anaemia)
- Cancer
- Cancer benefit enhancer
- Cardiomyopathy
- Carotid artery surgery
- Cerebral aneurysm
- Cerebral arteriovenous malformation
- Cerebral malaria
- Chronic kidney failure
- Chronic liver failure
- Chronic pancreatitis
- Chronic respiratory failure
- Coma
- Connective tissue disease
- Coronary artery bypass graft
- Crohn's disease with specified surgery
- Cushing's disease

(continued on page 4) Contract number

- [ ] Dementia (including alzheimers disease)
- [ ] Early bladder cancer
- [ ] Early breast cancer
- [ ] Early cervical cancer
- [ ] Early oesophageal cancer
- [ ] Early ovarian cancer
- [ ] Early prostate cancer
- [ ] Early testicular cancer
- [ ] Encephalitis
- [ ] Endocrine disorders
- [ ] Eye stroke
- [ ] Gastrointestinal stromal tumour
- [ ] Heart attack
- [ ] Heart surgery
- [ ] Heart transplant
- [ ] Heart valve replacement or repair
- [ ] Hematopoietic stem cell (bone marrow) transplant
- [ ] Inflammatory bowel disease
- [ ] Juvenile onset recurrent respiratory papillomatosis
- [ ] Kidney transplant
- [ ] Less extensive burns
- [ ] Life threatening arrhythmia
- [ ] LifeQuality
- [ ] Lifestyle enhancer
- [ ] Liver transplant
- [ ] Lobectomy
- [ ] Loss of hearing
- [ ] Loss of sight
- [ ] Loss of speech
- [ ] Lung transplant
- [ ] Major artery aneurysm
- [ ] Major burns
- [ ] Minor heart surgery
- [ ] Minor stroke
- [ ] Motor neurone disease
- [ ] Multiple sclerosis
- [ ] Muscular dystrophy
- [ ] Neuroendocrine tumours
- [ ] Pacemaker or defibrillator insertion
- [ ] Pancreas transplant
- [ ] Paralysis
- [ ] Parkinson's disease
- [ ] Parkinson's plus syndrome
- [ ] Pathway ablation
- [ ] Pericardiectomy
- [ ] Peripheral arterial disease
- [ ] Pneumonectomy
- [ ] Pulmonary arterial hypertension
- [ ] Pulmonary artery surgery
- [ ] Pulmonary embolism
- [ ] Recurrent pulmonary emboli
- [ ] Scleroderma
- [ ] Spinal cord tumour
- [ ] Status epilepticus
- [ ] Stroke
- [ ] Systemic lupus erythematosis
- [ ] Terminal illness
- [ ] Trauma
- [ ] Type I diabetes
- [ ] Ulcerative colitis
- [ ] Wegener's granulomatosis

When was the condition diagnosed? D D M M Y Y Y Y

* The Life Covered should only claim under the LifeQuality or Activities of daily living event if he/she does not qualify for the payment for any other illness.

SECTION 7 DECLARATION BY THE LIFE COVERED AND CONTRACTING PARTY

PROTECTION OF PERSONAL INFORMATION

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 are suitable to your financial needs.

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
- Claims checks
- Fraud prevention and detection
- Market research and statistical analysis
- Audit & record keeping purposes
- To comply with legal & regulatory requirements
- Verifying your identity
- Sharing with service providers we engage to process information on our behalf

You may access the information that we hold about you and ask us to correct any errors or delete the information we have about you. To view our full privacy notice and to exercise preferences, visit our website on www.oldmutual.com.na.

1. I hereby declare that the details provided in this form are true, correct and complete.
2. I declare that the medical condition 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 ____________ on this ____________ day of ____________ 20____

Signature of Contracting Party

Signature of Life Covered (if different to the Contracting Party)

Date D D M M Y Y Y Y

Contract number

Old Mutual Life Assurance Company (Namibia) Limited. Reg. no: 97/081