OLDMUTUAL

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Plan number (e.g. 12345678)

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

GREENLIGHT
DISABILITY BENEFIT CLAIM FORM
STATEMENT BY CLAIMANT

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

IMPORTANT: THE PREMIUM MUST CONTINUE TO BE PAID TO AVOID PLAN/BENEFITS CEASING.

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 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

BANKING DETAILS OF CONTRACTING PARTY (or Beneficiary, if different)

Name of bank

Branch name Branch code

Name of accountholder

Account number Account type: Cheque Savings Transmission

Accountholder relationship: Own account Joint account 3rd Party account

(Please enclose bank statement)

SECTION 2 INFORMATION REGARDING YOUR MEDICAL CONDITION

2.1 (a) Describe in your own words, the cause of your medical condition.

2.2 If your medical condition was due to an accident, please state:

(a) Names and addresses of witnesses or other persons involved.

(b) Address of police station (if any) to which the accident was reported and case number (if applicable).

2.3 Which parts of your body are affected by the medical condition?

2.4 What is the impact of the medical condition on the affected body parts?

2.5 Describe the impact of the medical condition on your ability to do the following:

(a) thinking clearly	
(b) concentrating	
(c) making decisions	
(d) interacting with others	
(e) walking	
(f) sitting in a chair	
(g) writing and typing	
(h) reading	
(i) operating machinery	
(j) carrying and lifting	
(k) driving	
(l) feeding	
(m) toileting	

2.6 Are there any other daily activities that are affected by your medical condition? YES ☐ NO ☐

If "YES", please describe in full.

Plan number

SECTION 3 DETAILS OF TREATMENT

3.1 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 name(s) and address(es) of all medical practitioner(s) and hospital(s) involved, and referral date(s).

Name	Address	Medical condition	Date	Duration

3.2 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 state the nature of the illness and give names and addresses of the doctors and hospitals consulted, including the dates of occurrence.

Name	Address	Medical condition	Date	Duration

3.3 Are you a member of a medical aid? YES ☐ NO ☐

Name of medical aid	
Member number	
Name of main member	

3.4 Do you feel your condition is improving because of the treatment? YES ☐ NO ☐
If "YES", please describe in full.

3.5 Has any medical practitioner given you advice or prescribed treatment for your medical condition that you have not adhered to? YES ☐ NO ☐
If "YES", please provide details.

SECTION 4 DETAILS OF OCCUPATION

4.1 What was your occupation when the medical condition commenced?

4.2 Please give a complete description of the duties and daily activities of your occupation or enclose a copy of your job description.

(a) Administrative duties ☐☐☐ %
(b) Manual duties ☐☐☐ %
(c) Supervisory duties ☐☐☐ %
(d) Travelling ☐☐☐ %

4.3 Please describe how your medical condition has affected your ability to perform each of the duties and daily activities listed in 4.2 above.

Plan number ☐☐☐☐☐☐☐☐☐☐

4.4 When do you expect to be able to resume your occupation? D D M M Y Y Y Y

4.5 For each occupational duty that you are no longer able to perform, please indicate when this inability began?

Occupational duty

	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

4.6 Were you engaged in any other occupation (permanent or part-time) immediately after your medical condition commenced? YES ☐ NO ☐

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

Name of occupation

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

SECTION 5 EDUCATION, TRAINING AND WORK EXPERIENCE

5.1 Please state details (with dates) of all occupations followed by you during the past 10 years.

Occupational duty

	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

5.2 What school, academic, professional or trade qualifications do you possess?

5.3 What alternative occupations do you consider yourself able to perform, with regard to your education, training or experience?

5.4 When do you expect to be able to begin the above alternative occupations?

On a full-time basis? D D M M Y Y Y Y

On a part-time basis? D D M M Y Y Y Y

5.5 Give the name and address of your most recent employer.

5.6 Have you been discharged from your present occupation? YES ☐ NO ☐

If "YES", please provide full details.

Plan number

5.7 If self-employed, is your business being conducted on your behalf while you are unable to work? YES ☐ NO ☐

If "YES", please provide full details.

If "NO", which of the following duties do you still perform?

(a) Administrative duties ☐☐☐ %

(b) Manual duties ☐☐☐ %

(c) Supervisory duties ☐☐☐ %

(d) Travelling: car/truck ☐☐☐ %

5.8 Are you currently receiving any form of disability compensation? YES ☐ NO ☐

If "YES", please provide details (amount, type of benefit, recurring/lump sum, company, reference number).

5.9 Is any other disability claim on your life pending or contemplated? YES ☐ NO ☐

If "YES", please provide details (amount, type of benefit, recurring/lump sum, company, reference number).

SECTION 6 INCOME INFORMATION

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

6.2 Please provide details of any income or benefit you are receiving from your pre-disability employer. Indicate how long you expect this income or benefit to continue for.

6.3 Have you been engaged in any occupation (full or part-time) since your medical condition arose? YES ☐ NO ☐

If "YES", please provide full details of the occupation as well as full details of earnings in this occupation.

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 Republic of Namibia in the past 12 months? YES ☐ NO ☐

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

Plan number ☐☐☐☐☐☐☐☐☐☐

SECTION 8 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 (LAAN Life & Claims Register)
- 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 that led to the disablement 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)

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Plan number