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Maternity Benefit Claim Form

GREENLIGHT

GREENLIGHT Plan Number (e.g. 12345678)

Grid for Plan Number

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

Grid for Intermediary Code

Please print in block letters using black or blue ink.

This form is issued without admission of liability and must be signed by the claimant and forwarded to:

GREENLIGHT Service Centre
PO Box 165
Windhoek
Namibia
Tel. 061 239 527
Fax. 061 246 795

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 who delivered the baby.

IMPORTANT NOTES

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

- 1. A certified copy of the Life Covered's and Beneficiary's ID.
2. Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead.
3. Please continue paying your monthly contributions to avoid benefits ceasing.

PART 1 - TO BE COMPLETED BY THE CLAIMANT

DETAILS OF CONTRACTING PARTY

Form fields for Contracting Party details including Title, Surname, First names, ID number, Passport number, Date of birth, Income tax number, Residential address, Telephone, Fax, Email address, and Marital status.

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 selection fields: Black, Indian, Coloured, White



**DETAILS OF CHILD**

Name(s)

Surname

ID number

Date of birth

Gender: Male  Female

**DECLARATION OF CONTRACTING PARTY**

**PROTECTION OF PERSONAL INFORMATION (PPI) 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 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 (ASISA 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](http://www.oldmutual.com.na).

I hereby declare that the Life Covered is the person assured under the abovementioned Benefit(s), that all the particulars given are true and complete.

Signed at  this  day of  year

Signature of CONTRACTING PARTY

Signature of WITNESS

Date

**PART 2 - TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER**

I confirm that \_\_\_\_\_ (name of the mother),  
 gave birth on \_\_\_\_\_ (date), to a baby \_\_\_\_\_ (gender of baby).

I certify that I have personally attended to the Life Covered and that the foregoing statement is correct to the best of my knowledge.

Initials  Surname

Practice number

Qualifications

Address  Postal code

Telephone Code  Number

Fax Code  Number

Signed at  this  day of  20

Signature of Medical Practitioner

**DOCTOR'S  
OFFICIAL  
STAMP**

Contract number