OLDMUTUAL

GREENLIGHT

NAM CHILD 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. **Fully completed Child Severe Illness Benefit Claim Form Statement by Contracting Party.**
2. **Fully completed Child Severe Illness Benefit Claim Form Statement by Medical Specialist.**
3. **A certified copy of the Life Covered's ID.**
4. **Proof of birth of child, i.e. certified copy of unabridged birth certificate or certified copy of Confirmation of Birth form issued by hospital at the time of birth.**
5. **Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead.**
6. **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 impairment. Please contact the Claims Call Centre at 061 239 548 for more details.

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

Child Severe Illness Benefit Claim Form CP omms 08.2014 L7433 NAM

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 ☐

DETAILS OF CHILD

Name(s)

Surname

ID number Date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female

Is the child an adopted child of the Life Covered? YES ☐ NO ☐

Name of father

ID number
of father

Name of mother

ID number
of mother

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 ☐

Contract number

MEDICAL HISTORY

When was the child's current condition diagnosed? D D M M Y Y Y Y

Who initially diagnosed the child's condition?

Doctor's name	
Contact number	

Please provide the name(s) and address(es) of all medical practitioners and hospitals involved in the child's medical care, and referral dates.

Name	Address	Date	Duration

DETAILS OF THE CHILD'S CONDITION

What condition is being claimed for? Please tick the relevant block.

- ☐ Accidental HIV via a blood transfusion
- ☐ Accidental HIV via an organ transplant
- ☐ Acquired mental retardation
- ☐ AIDS
- ☐ Bacterial meningitis
- ☐ Benign brain tumour
- ☐ Bone marrow failure (including aplastic anaemia)
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Chronic kidney failure
- ☐ Chronic respiratory failure
- ☐ Coma
- ☐ Heart surgery
- ☐ Heart transplant
- ☐ Hematopoietic stem cell (bone marrow) transplant
- ☐ Juvenile onset recurrent respiratory papillomatosis
- ☐ Juvenile rheumatoid arthritis
- ☐ Kidney transplant
- ☐ Liver transplant
- ☐ Loss of hearing
- ☐ Loss of sight
- ☐ Lung transplant
- ☐ Multiple sclerosis
- ☐ Pancreas transplant
- ☐ Paralysis
- ☐ Spinal cord tumour
- ☐ Stroke
- ☐ Terminal illness
- ☐ Type I diabetes

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's child 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

OLDMUTUAL

Contract number