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Sanlam Risk Benefits

2737E

Claim for Trauma / Dread disease

Please return the completed form to: **Living Benefit Claims**

Postal address	PO Box 1, Sanlamhof 7532	Telephone number	(021) 916-3455
e-mail address	livingbenefits@sanlam.co.za	Fax number	(021) 947-5804

For Namibian policies refer to: claims.affluentsupport@sanlam.com.na or contact our Sanlam Namibia office at +264 61 294 7440.

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.
- It is also important that you should be aware of the implications of the non-payment /payment of this claim for your financial position. We therefore strongly recommend that at this stage you should already contact your financial advisor to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail, fax or per post. If readable copies of documents are provided to us, the original documents are unnecessary.

Please supply the following documents:

- A copy of your identity document
- Copies of all specialist reports in your possession as well as copies of all special and laboratory tests. You are responsible for the costs relating to this medical information.
- Sanlam will request further medical information/documents if required.

You can only claim for the illnesses listed in your own contract.

Particulars of insured life

Plan number(s) _____ _____ _____

_____ _____ _____

Surname _____

Full first names _____

Date of birth _____ (dd/mm/ccyy)

Identity number _____ (Compulsory) Land of issue _____

Passport number _____ Expiry date _____ (dd/mm/ccyy)

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev ☐ Dr ☐ Prof ☐ Adv ☐ Judge ☐

Gender Male ☐ Female ☐

Postal address _____ Postal code _____

Residential address _____ Postal code _____

Contact details: Telephone (home) (____) _____ Fax (home) (____) _____

Telephone (work) (____) _____ Fax (work) (____) _____

Cell phone _____

e-mail address _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Race White ☐ Asian ☐ Coloured ☐ Black ☐ Unknown ☐ (For statistical purposes)

Nature of claim and particulars of consultations

- For what illness stipulated in your contract do you claim?

_____

_____

- Describe the symptoms which you are experiencing and state the date the symptoms began.

_____

_____

- On which date did you consult a doctor regarding these symptoms? _____ (dd/mm/ccyy)

Plan number(s) _____

- State the initials, surname, address of this doctor, as well as the telephone number.

_____

Telephone number (____) _____ Fax number (____) _____

Medical history

- State the initials, surname, address and telephone number of your:
  - Present family doctor _____

    Telephone number (____) _____ Fax number (____) _____
  - Previous family doctor _____

    Telephone number (____) _____ Fax number (____) _____
- Since which date have you been consulting your present family doctor? _____ (dd/mm/ccyy)
- State the date when you last consulted your family doctor. _____ (dd/mm/ccyy)

Details of doctors, specialists and consultations you consulted regarding the condition that caused the claim.

Name and surname	Type of specialist	Address	Telephone number	First consultation (dd/mm/ccyy)
			( )	
			( )	
			( )	
			( )	

State the initials, surname, address and contact number of the doctor(s) who referred you to the specialist(s) mentioned above:

_____

Telephone number (____) _____ Fax number (____) _____

_____

Telephone number (____) _____ Fax number (____) _____

Other Trauma/Dread disease insurance

Trauma / Dread disease insurance at other insurers (irrespective of whether a claim has been submitted):

Name of insurer	Plan- / Reference number	Sum insured (R)	Cessation date (dd/mm/ccyy)

Plan number(s) _____

Payments

Please note that the payments must be continued until a claim, if any, has been admitted.

Bank particulars

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead containing the account number and account holder's name.

Please complete **ONE** of the 3 options provided.

1. Details of account holder/plan holder

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issuing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ (dd/mm/ccyy)

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ (dd/mm/ccyy)

Residential / Business address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐

Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐

Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐

Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐

Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐

Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other (specify) _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of account holder _____ Date _____ (dd/mm/ccyy)

Plan number(s) _____

2. Payment to cessionary

Important
If any plan, in terms of which a claim is admitted, has been ceded to another institution or person, payment will be made directly to the cessionary in question. The next section must be completed by the cessionary if applicable.

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issuing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ (dd/mm/ccyy)

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ (dd/mm/ccyy)

Residential / Business address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐
Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐
Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐
Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐
Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐
Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other (specify) _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Or

Plan number(s) _____

Payment to cessionary (continued)

I hereby give permission for the cession to be cancelled.

Name of contact person _____ Contact number: (____) _____

Signature of cessionary _____ Official stamp of institution _____

Date _____ (dd/mm/ccyy)

3. Proxy and/or payment to a third party

If the plan owner would prefer the claim/payment to be handled/received by another person/institution, please provide us with the details below:

I, _____ (first names and surname of the plan holder),

hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Sanlam Life against any and all claims in respect of, and in connection with, the payment by Sanlam of the amount(s) concerned to this third party. (Delete where not applicable)

Initials and surname of the person that could handle the claim on my behalf: _____

Address _____

_____

_____ Postal/Zip code _____

Initials and surname of the person that could receive the payment on my behalf: _____

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issuing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ (dd/mm/ccyy)

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ (dd/mm/ccyy)

Residential / Business address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐

Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐

Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐

Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐

Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐

Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

Registration number _____ Country of registration _____

Plan number(s) _____

Proxy and/or payment to a third party (continued)

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

Source of funds _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other (specify) _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of plan holder _____ Date _____ (dd/mm/ccyy)

Declaration

I declare that the particulars contained in this form are correct. I also irrevocably authorise any person or institution, medical practitioner, medical specialist, hospital, nursing institution or medical authority to provide Sanlam Life with any information that may be required regarding my health.

Further, I irrevocably authorise Sanlam Life to share with other insurers or any other stakeholders for the purposes of assessing, investigating, processing or any other reason including prevention of fraudulent claims that information and any information contained in this plan or any related plan or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Sanlam Life or by the operators of such data base.

Signature of insured/claimant _____

Date _____ (dd/mm/ccyy)