



Claim for Child Benefits for Living benefits or Death benefits

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

Postal address PO Box 1, Sanlamhof 7532
e-mail address livingbenefits@sanlam.co.za

Telephone number (021) 916-3455
Fax number (021) 947-5804

Important

- Form to be completed by the owner of the plan.
- 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.
- 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.
- 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 owner of the plan's as well as the insurable child's identity documents.
- Copies of all specialist reports as well as copies of all special and laboratory tests. The planholder is responsible for the costs relating to this medical information.
- A certified copy of the official death certificate issued by the Department of Home Affairs (if it is for a death claim).
- Sanlam will request further medical information/documents if required.

Please note: A claim can only be considered for the illnesses/injuries listed in the contract.

Particulars of plan holder

Plan number(s) _____

Title: Mr Mrs Miss Ms Rev Dr Prof Adv Judge

Surname _____

Full first names _____

Date of birth _____ (dd/mm/ccyy) Date of death (if applicable) _____ (dd/mm/ccyy)

Identity number _____ (Compulsory) Land of issue _____

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

Postal address _____ Postal code _____

Residential address _____ Postal code _____

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

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

Cell phone _____

e-mail address _____

Particulars of insurable child

Surname _____

Full first names _____

Date of birth _____ (dd/mm/ccyy)

Identity number _____ (Compulsory) Land of issue _____

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

Gender: Male Female

Plan number(s) _____

Nature of claim and particulars of consultations

- For what illness/injury stipulated in the contract is the claim for? If the claim is as a result of death, please indicate what the cause of death was.

- Describe the symptoms/injury which the child is experiencing and state the date these symptoms began or injury occurred. If the claim is as a result of death, please provide details of the cause of death - was it **Natural** (for example: an illness) or **Unnatural** or **Unknown** (for example: accident/murder).

- On which date did the child first consult a doctor regarding these symptoms/injury? _____ (dd/mm/ccyy)
- State the initials, surname, address of this doctor, as well as the telephone number.

Telephone number () _____ Fax number () _____
 e-mail address _____

Medical history

- State the initials, surname, address and telephone number of ::

- Present family doctor _____
 Telephone number () _____ Fax number () _____
 E-mail address _____

- Previous family doctor _____
 Telephone number () _____ Fax number () _____
 E-mail address _____

- Since which date have the child been consulting the present family doctor? _____ (dd/mm/ccyy)
- State the date when the child last consulted the family doctor. _____ (dd/mm/ccyy)

Details of doctors, specialists and consultations the child 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 the child to the specialist(s) mentioned above:

Telephone number () _____ Fax number () _____
 e-mail address _____

Telephone number () _____ Fax number () _____
 e-mail address _____

Plan number(s) _____

Previous illnesses/injuries of child

Illness/Injury	Treatment plan	Date (dd/mm/ccyy)

Other Trauma/Dread disease/Death insurance

Trauma/Dread disease/Death 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)

General Information

Are you one of the following to the child?

Parent Legal guardian

Is the child one of the following:

Biological child Legally adopted child Step child

Is the child financially dependent on you?

Yes No

If "Yes", please give reason (example, indigenous law, custom, court of law, studying) _____

Payments

Please note that the payments on the plan 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. A confirmation letter from the bank confirming the banking details is also acceptable.

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)

Plan number(s) _____

Details of account holder/plan holder (continued)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)

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 _____

Plan number(s) _____

Payment to cessionary (continued)

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

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: _____

Plan number(s) _____

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

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, the owner of the plan, 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 insurable child's 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 proposal 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 the death of the insurable child) 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 plan holder _____ Date _____ (dd/mm/ccyy)