Claim for Critical Illness Benefit

Confidential

Contents

The following forms must be completed for the submission of a Critical Illness claim.

The forms consist of:

- Critical Illness claim: Declaration by fund/scheme – Form to be completed by employer.
- Statement by insured for a Critical Illness claim – Form to be completed by the claimant.
- Questionnaire to doctor: – Form to be completed by claimant's treating specialist as well as the compiling of the report.

Critical Illness

Very important: If there are any existing specialist reports available please forward copies with the claim documents.

General

- The claimant has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.
- The claimant is obliged to submit whatever medical or other information Absa Life may reasonably require.

The employer must either post or email the duly completed forms to:

Absa Group Schemes
3rd Floor
Towers North
180 Commissioner Street
Johannesburg, 2001
Email: sufsclaims@absa.co.za

Critical Illness Claim: Declaration by fund/scheme

Particulars of fund/scheme

Name of fund/scheme | Scheme code

Email of contact person | Telephone number

Postal address

Name of branch/participating employer

Particulars of the member/insured

Full first names and surname

Date of birth (dd/mm/ccyy) | Gender: Male | Female

Marital status: Single ☐ Married ☐ Divorced ☐ Co-habit ☐ Widowed ☐

Occupation | Identity number

What illness, impairment has led to this claim?

Particulars of membership

Membership number | Pay-sheet no. (if any)

Date of entering service (dd/mm/ccyy) | Date of permanent appointment

Date of commencement of membership (dd/mm/ccyy)

Annual pensionable remuneration of member		**Date granted (dd/mm/ccyy)**
i On fund/scheme anniversary before Critical Illness incident:	**R**	
ii On date of Critical Illness incident:	**R**	
iii One year immediately before Critical Illness incident:	**R**	

If (ii) differs from (i), state the date of the increase (dd/mm/ccyy)

Did the member/insured qualify for membership of the fund/scheme on the date of commencement of Critical Illness? Yes | No

We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.

Signature on behalf of the fund/scheme

Date (dd/mm/ccyy) | Place

Signature | Designation

Signature | Designation

Statement by insured for a Critical Illness claim

Name of fund/scheme

Name of insured

Insured's date of birth (dd/mm/ccyy)

Telephone number

Membership number

Cell

Identity number

Email address

Nature of illness or impairment

1 Name and address of your regular family doctor

2 Since what date has he/she been your family doctor? (dd/mm/ccyy)

3 Mention date of last consultation (dd/mm/ccyy)

4 Who was your previous family doctor?

5 Which illness or impairment has led to the claim?

6 On what date did you see a doctor about this for the first time? (dd/mm/ccyy)

7 What was the name of this doctor?

8 Please state the names of all other doctors you have consulted in this regard

9 If this claim resulted from an accident, please give the following information:

9.1 Date of accident? (dd/mm/ccyy)

9.2 Circumstances causing the accident.

9.3 If a formal enquiry was conducted, please state by whom and what the result was.

General

Do you have Critical Illness assurance with other companies? Yes No

If so: Name of the company

Sum assured **R**

Inception date (dd/mm/ccyy)

Please give any other information which, in your opinion, may influence the claim.

Payment of benefits

Personal information

Postal address			
Residential address			
Telephone number (W)		(H)	

If the benefits are to be paid into the beneficiary's bank account, please provide us with a cancelled cheque or a certified deposit slip in the case of a savings account as well as the following information:

Name of bank	
Branch code	
Branch of bank	
Type of account	
Account number	

I declare that I am the person described above and that the replies given to the questions and the statements made above are true and correct. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks and the consideration of any claim for benefits under a policy related to this or any other proposal for insurance made by me, or in respect of me as insured, I irrevocably authorise Absa Life to:

- obtain from any person whom I hereby so authorise and request to give any information which Absa Life deems necessary; and
- share with other insurers that information contained in this proposal or in any related policy 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 Absa Life or by the operators of such database.

Signature

Date (dd/mm/ccyy)		Place	
		Witness	

Signature

Questionnaire for doctor: Critical Illness

Name of fund/scheme

Membership number

Name of branch/participating employer

Name of claimant

Insured's date of birth (dd/mm/ccyy)

Identity number

Dear Doctor

Please provide us with the information requested below. The claimant has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.

A General (To be completed at all times)

Are you the insured's family doctor? Yes No

If you are, from what date is the claimant your patient? (dd/mm/ccyy)

If not, please give his/her name if known to you

Please give full details of previous or other abnormal physical or mental conditions about for which you have been consulted.

Nature	**Date of consultation (dd/mm/ccyy)**	**Duration**

Please state the name and address of any other doctor the insured consulted.

Doctor	**Condition**	**Date of consultation (dd/mm/ccyy)**	**Duration**

Date of first consultation (dd/mm/ccyy)

Date of diagnosis/loss/incident (dd/mm/ccyy)

B Minimum medical requirements for the insured's illness

Important: The insured can only claim for the illnesses listed in the relevant contract and not all the illnesses listed below.

Cancer
- Up to date clinical report from the treating medical specialist.
- Pathology report(s).

Myocardial infarction
- Clinical report including date of diagnosis, extent of infarction (transmural or sub-endocardial).
- All ECG's available (old and new).
- Serial Cardiac enzymes (CK, CK-MB fraction): copy of lab reports.
- Cardiac markers (e.g. trop T).
- Other: Reports of echocardiogram, angiogram.

Stroke
- Clinical Report after maximal medical improvement has been reached indicating permanent neurological impairment.
- Copy of brain scans.

Coronary artery bypass surgery
- Cardiologist report.
- Operation report.

Heart valve replacement
- Cardiologist report.
- Operation report.

Aortic artery surgery
- Surgeon report.
- Operation report.

Arrythmia
- Up to date cardiologist report.
- Operation report regarding pacemaker, defibrillator or ablation.

Cardiomyopathy
- Up to date cardiologist report including the ejection fraction and exercise test to determine amount of METS reached on maximal exercise.
- Echocardiography.

Blindness
- Ophthalmologist report with visual acuity before and after correction.
- Visual fields where applicable.

Organ transplant
- Specialist report.
- Operation report.

Chronic renal failure
- Clinical report indicating period of dialysis.
- Up to date kidney functions (blood tests).

Sero-positive rheumatoid arthritis
- Rheumatologist report with details of treatment administered.
- Blood tests (rheumatoid factor).

Multiple sclerosis
- Up to date neurologist report, with details of chronological progression of disease.
- Special investigations: scans.

Parkinson's disease
- Neurologist report

Loss of limb function
- Clinical report indicating diagnosis, amputation level, range of movement, power, sensation, deformities.
- X-rays, EMG, Doppler studies (where applicable).

Benign brain tumor
- Clinical report indicating neurological impairment.
- Scans.
- Pathology reports.

Pulmonary embolism
- Clinical report.
- Ventilation-perfusion scan (VQ).

Total deafness
- Clinical report.
- Oudiogram with speech discrimination.

Accidental HIV infection
- Clinical report.
- Injury report or Police report.
- HIV blood tests: results of claimant and patient involved in injury/incident.
- Pre-seroconversion proof of negative HIV status.

Alzheimer disease
- Clinical report from psychiatrist indicating DSM diagnosis and restrictions of activities of daily living.
- Copies of psychometric tests done.

Motor neuron disease

- Up to date neurologist report.

Muscular dystrophy

- Neurologist report including description of functional impairment.

Aplastic anaemia

- Haematologist report.
- Bone marrow report.

Coma (more than 96 hours, not medically induced)

- Detailed clinical report of the causes, diagnosis, reason for ventilation, clinical progression, time of ventilation and parenteral feeding.
- Glasgow coma scale on admission and during ventilation.
- Copies of all hospital records.

Major burns

- A detailed description of third degree (not first and second degree) burn wounds is needed. (% of body surface affected)
- Cause and date of incident.
- The attached diagram can be used to show the extent of the third degree burns.

Liver failure

- Clinical report from treating specialist.
- Copies of special investigations done (e.g. liver function tests, liver biopsy).

End stage lung disease

- Clinical report from pulmonologist or physician.
- Lung function tests, diffusion capacity (DCO).

Medical practitioner's information and signature

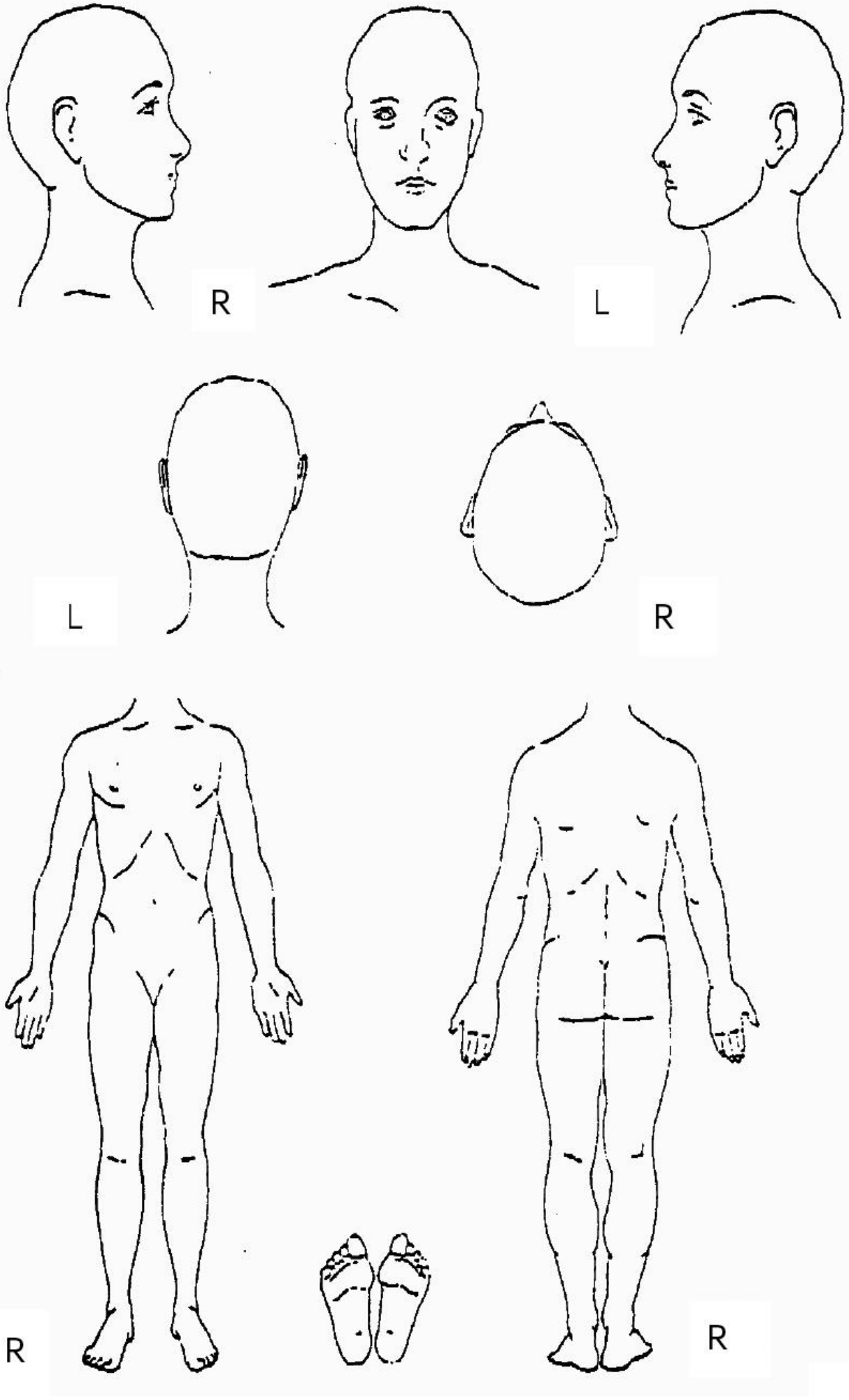
Initials and surname			
Practice number		Qualifications	
Address			
Telephone number (W)		(H)	
Email			

Date (dd/mm/ccyy) | | | | | | | | |

Signature

Declaration

By signing the Questionnaire, I guarantee that all information that I have given you is true and accurate to the best of my knowledge and can be relied on.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