Claim for Trauma / Dread disease

Please return the completed form to: **Policy claims**

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

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 ________________

Pass port 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)*
- State the initials, surname, address of this doctor, as well as the telephone number.

____

Telephone number (   ) ________________ Fax number (   ) ________________

Plan 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
			/ /
			/ /
			/ /
			/ /

Payments

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

Licensed Financial Services and Registered Credit Provider (NCRCP43)

Plan number ______________________________

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. Payment to the owner of the plan(s).

If the claim of the life insured is admitted, Sanlam Life can make the money available by means of an electronic bank transfer to the owner of the plan. Please provide us with the following details:

Name of bank ____________________ Name of branch ____________________

Account number ____________________ Branch code ____________________

Account holder ______________________________

Type of account Cheque ☐ 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.

Complete if any of your policies are ceded:

Relevant plan number(s) ______________ ______________ ______________

Name of bank ____________________ Name of branch ____________________

Account number ____________________ Branch code ____________________

Account holder ______________________________

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ ____________________ *(Specify)*

Or

I hereby give permission for the cession to be cancelled: ____________________

Name of contact person ____________________ Contact number: (   ) __________

Signature of cessionary ____________________ Official stamp of institution Signature of cessionary ____________________

Date ____/____/________ *(dd/mm/ccyy)*

Plan number ______________________________

Bank particulars *(continued)*

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, (plan owner) first names and surname: ______________________________

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 code __________

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

Identity number ______________________________

Name of bank ____________________ Name of branch ____________________

Account number ____________________ Branch code ____________________

Account holder ______________________________

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ ____________________ *(Specify)*

Signature of plan owner ______________________________

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 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 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)*