Claim for Accident benefit / Physical impairment benefit / Functional Impairment

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

This is a generic claim form. Please indicate below for which benefit you submit a claim and take note of the requirements for the specific benefit claim.

I submit a claim for: Accident benefits ☐ Physical Impairment ☐ Functional Impairment ☐

Plan number ______________________________

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 understand 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 note: A claim can only be submitted for the claim events as stipulated in the contract, on all the above-mentioned benefits.

Accident benefits/Physical impairment benefits

Please supply the following documents:

- A copy of your identity document
- Report according to the "Minimum format of report regarding Accident/Physical benefit claims. (This form part of this claim form and must be handed to treating doctor/specialist physician to compile)
- SAPS report or Injury on duty report regarding the accident.
- If the claim reason is burns wounds, then also complete the form *Engburns (Annexure Burnwounds)* on which the extend of the burns should be indicated by the doctor.
- If the claim reason is amputation, then also complete the form *Enghandleft (Draft of hand left)* or *Enghandright (Draft of hands right)* on which amputation should be indicated by the doctor.

Functional impairment benefits

Please supply the following documents

- A copy of your identity document
- Copies of all available medical reports, X-rays, MRI scans and special medical tests done.
- SAPS report or reports of injury sustained at work if a claim was caused by an accident on duty, as well as the result of the investigation if already finalised.
- The attached *Report by the treating Specialist*.

Licensed Financial Services and Registered Credit Provider (NCRCP43)

Plan number ______________________

Particulars of insured life

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 ☐

Current main occupation ______________________

Since when have you been engaged in this occupation? ___/___/______ *(dd/mm/ccyy)*

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

Nature of claim and particulars of consultations

- For what contractual listed illness, injury or deviations do you claim?

  ____

  ____

- Describe the loss which you are experiencing as a result of the accident when the loss occurred.

  ____

  State from which date the loss was experienced. ___/___/______ *(dd/mm/ccyy)*

- On which date did you consult a doctor regarding these symptoms for the 1st time? ___/___/______ *(dd/mm/ccyy)*
- State the initials, surname, address and telephone number of this doctor:

  ____

  ____

  Telephone (work) ( ) ______________ Fax (work) ( ) ______________

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)*
- Provide the following information with regard to all other doctors/specialists you have consulted regarding the condition that caused the claim.

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Plan number ____________________

Medical history *(continued)*

Details of doctors, specialists and consultations

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

Public Healthcare

Name of hospital	Name of Specialist	Patient number	Telephone number	first consultation dd / mm / eeyy
			( )	/ /
			( )	/ /
			( )	/ /
			( )	/ /

Accident particulars

- Date of accident ____/____/________ *(dd/mm/ccyy)*
- Place of accident ____________________
- The disability was caused by ☐ Motor vehicle accident ☐ Accident at home ☐ Accident at work ☐ Shooting accident ☐ Other *(specify)* ____________________
- Give a brief description of how the accident happened:

____

____

____

- If there was an investigation into the cause of the accident, provide the following:

  Name of police station ____________________

  Case number ____________________

  Initials and surname of investigating officer ____________________

  Contact details Telephone number ( ) ____________ Fax number ( ) ____________

  Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report):

  ____

  ____

- Did you suffer any physical loss? Yes ☐ No ☐

  If "Yes", describe the nature of the loss you suffered

  ____

  If the loss did not happen on the date of the accident, please state the date ____/____/________ *(dd/mm/ccyy)*

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Plan number ______________________________

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. 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)*

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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: ______________________________

Identity number ______________________________

Address ______________________________ Postal code __________

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

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)*

Plan number ______________________________

Minimum format for compiling a report regarding accident/physical impairment benefit claim

In support of a claim of the accident benefits of the plan/plans ____________ ____________

on the life of ______________________________ born ____/____/______ *(dd/mm/ccyy)*

Before you perform the examination, please determine the client's identity with the help of a photographic proof of identity. Indicate on the report of your findings – what type of proof of identity was given.

To consider the claim, we require a report containing the information below in respect of the specific loss/injury that the claimant suffered. The claimant will bear the cost of the report. Sanlam Life has the claimant's permission to disclose the information.

Guidelines: Medical report *(This list is a guideline only)*

1. The date of the accident.
2. The occupation of the claimant.
3. When did the physical loss take place?
4. If you are the claimant's regular doctor.
   - If not, please provide the family doctor's name and telephone number.
   - If so, please provide information and dates of any relevant illnesses or injuries about which you were consulted.
5. If you are at any stage aware of excessive use of alcohol, please provide the full information.
6. If the claimant was ever tested for HIV antibodies. If so, what the result was.
7. The benefits will only be payable for the loss of use of certain limbs, the amputation thereof or certain other injuries/illnesses stipulated in the contract. Please state the bodily loss/injury sustained and compile a clinical report according to the following requirements/guidelines per loss/injury. (Please provide copies of all specialist reports, and/or x-rays in your possession.

   Vision loss
   - Vision acuity pre- and post-correction
   - Visual field where applicable

   Hearing loss
   - Audiogram with speech discrimination

   Burns
   - Indicate the areas of third degree burn wounds on attached sketch

   Coma
   - The Glasgow Coma scale from admission to discharge
   - Periods of ventilation and intravenous need to be indicated. (Specify dates)
   - Medication administered during the period of the coma.

   Amputation
   - Sketches indicating the level of amputation

   Paraplegia and Quadriplegia
   - Diagnosis and clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)

   Penetrating gun-shot wounds and stab wounds
   - Operation report

   Fractures : (ribs/pelvis/spine)
   - Radiological reports
   - Neurological impairment with spine fractures

   Loss of bowel or bladder function
   - Only the clinical report

   Loss of function of a limb
   - Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological impairment

   Post-traumatic fat-embolism
   - Report of ventilating/perfusion (VQ) scan

   Liver and spleen rupture
   - Operation report

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