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Claim for a Sickness benefit

Contact details for Cobalt for Professional Personal Cover

Telephone number: (021) 916-3455
Fax number: (021) 957-2288
e-mail address: sickness@sanlam.co.za

Important:

- An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.
- You should be aware of the implications of the payment or non-payment of this claim for your financial position.
- We strongly recommend that at this stage you should 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 post.
- Legible copies of original documents may be submitted instead of the originals.

The following compulsory documents must be submitted together with this claim:

- The attached *Declaration by attending doctor or dentist for a Sickness benefit claim* (*pages 5 and 6 of this form*).
- Legible copies of certificates of illness provided by attending doctor or dentist. *(If available.)*

Please note: If abroad, provide all medical documentation in English.

Particulars of insured life

Plan number(s) _____ _____ _____

_____ _____ _____

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

Gender Male ☐ Female ☐

Surname _____

Full first names _____

Date of birth ____/____/____ *(dd/mm/ccyy)*

Identity number _____ *(Compulsory)* Land of issue _____

Pass port 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 _____

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

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

Plan number _____

Nature of claim and particulars of consultations

Your current full-time occupation _____

Are you self-employed? Yes ☐ No ☐

Period of incapacitation From ___/___/___ *(dd/mm/ccyy)* To ___/___/___ *(dd/mm/ccyy)*

Are you currently working part-time? Yes ☐ No ☐

If "Yes", what is your part-time occupation? _____

Give a full description of the duties you were unable to perform.

_____

_____

_____

Is the claim due to Illness ☐ Injury ☐ *(Please mark the applicable option with an X)*

Describe the nature of the illness or injury

_____

_____

_____

Date when the illness first started or symptoms were experienced/injury occurred ___/___/___ *(dd/mm/ccyy)*

Were you hospitalised? Yes ☐ No ☐

If "Yes", please give the name of the hospital _____

Admission date ___/___/___ *(dd/mm/ccyy)* Discharge date ___/___/___ *(dd/mm/ccyy)*

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)*

Particulars of the treating doctor or dentist **(including doctors outside South Africa)**

Information of the doctor(s) and/or dentist(s) that attended to you, in respect of this claim or current capacity.

Details of doctors, specialists and consultations (also doctors outside South Africa)

Practitioner: Initials and surname	**Consultation date** dd / mm / ccyy	**Telephone number**	**Fax number**	**Medical Board Registration number**
	/ /	( )	( )	
	/ /	( )	( )	
	/ /	( )	( )	
	/ /	( )	( )	

Plan number _____

Particulars of the treating doctor or dentist *(continued)*

Details for hospitalisation for special investigations or treatments

Name of hospital	Reason for hospitalisation	Patient number	Admission dd / mm / ccyy	Discharge dd / mm / ccyy
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

State the initials, surname and contact details of the doctor who referred you to the Specialist:

_____

Telephone number ( ) _____ Fax number ( ) _____

Other information

In which country did the illness or injury originate? _____

If the illness or injury occurred in a country outside South Africa, please provide the following:

Country visited _____

Reason for visit _____

Date of arrival / / *(dd/mm/ccyy)* Date of return / / *(dd/mm/ccyy)*

Are you pregnant? Yes ☐ No ☐ If "Yes", estimated date of delivery / / *(dd/mm/ccyy)*

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.

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

If the claim of the insured is admitted, Sanlam Life can make the money available by means of an electronic bank transfer to the plan owner. 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)*

Plan number _____

Bank particulars *(continued)*

2. Payment to cessionary (Complete if any of your policies are ceded)

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.

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)*

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 of insured

- I declare that the particulars contained in this form are correct.
- I 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.
- Sanlam Life to share with other insurers this 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)*

Declaration by attending doctor/dentist for a Sickness Benefit claim

Important:

- *To be completed by the attending doctor/dentist only. (If abroad, provide all medical documentation in English)*
- *Any cost involved to complete this form is the responsibility of the claimant.*
- *An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.*
- *Legible copies of original documents may be submitted instead of the originals.*

Please supply the following additional completed document:

- Legible copies of certificates of illness provided by attending doctor or dentist. *(If available.)*

Contact details for Cobalt for Professional Personal Cover

Telephone number: (021) 916-3455
Fax number: (021) 957-2288
e-mail address: sickness@sanlam.co.za

Plan number(s) _____

Particulars of claimant

Surname _____

Full first names _____

Date of birth _____ *(dd/mm/ccyy)*

Nature of claim and particulars of consultations

State the initials, surname and contact details of the doctor who referred the patient to you:

_____

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

The claimant first consulted me for this current condition on _____ *(dd/mm/ccyy)*

Follow-up consultation dates _____ *(dd/mm/ccyy)*

_____

_____

_____

Primary diagnosis _____

Diagnostic code (ICD -10) for primary diagnosis _____

Secondary diagnosis _____

Diagnostic code for secondary diagnosis (ICD -10) _____

As a result of the above diagnosis the claimant was **totally** unable to fulfil his/her professional duties for the period:

From _____ *(dd/mm/ccyy)* To: _____ *(dd/mm/ccyy)*

Was the sick leave due to: Illness ☐ Injury ☐ *(Please mark the applicable option with an X.)*

Describe the nature/details of the illness or injury

_____

_____

Date when the illness first started/injury occurred _____ *(dd/mm/ccyy)*

Was the claimant hospitalised? Yes ☐ No ☐

If "Yes": Admission date: _____ *(dd/mm/ccyy)* Discharge date: _____ *(dd/mm/ccyy)*

Plan number(s) _____

Was any surgery performed? Yes ☐ No ☐

If "Yes", please specify the type of operation/procedure.

_____

_____

Date of operation _____ *(dd/mm/ccyy)*

Operation code (CPT4) _____

Were there any complications, which prolonged the sick leave beyond what can be reasonably expected for a condition of this nature? *(Please include copies of specialist reports.)* Yes ☐ No ☐

If "Yes", please comment on these complications as well as the reason for the extended sick leave.

_____

_____

_____

_____

_____

Is the insured currently at work? Yes ☐ No ☐

Particulars of doctor/dentist

Full names and surname _____

Medical Board Registration Number _____

Qualification _____

Practice number _____

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

Postal address _____

_____

e-mail address _____

Signature of doctor/dentist _____

Date _____ *(dd/mm/ccyy)* Place _____