Claim for Critical/Severe Illness

Contents

The following forms must be completed for the submission of a critical/severe illness claim.

The forms consist of:

- Critical/Severe Illness claim: Declaration by fund/scheme (Page 2) - Form to be completed by employer.
- Statement by insured for critical/severe illness claim (Page 3 and 4) - Form to be completed by the claimant.
- Questionnaire for medical practitioner/doctor: Critical/Severe Illness (Page 5 - 10) - Form to be completed by claimant's treating specialist as well as the compiling of the report according to the *Claim Requirements: Guidelines for Critical/Severe Illness insurance*.

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

Please supply the following documents:

- A copy of the claimant's identity document
- Copies of all existing specialist reports as well as copies of all special and laboratory tests. The claimant is responsible for the costs relating to this medical information.
- If the claim is as a result of burns, please request the *BURNS_E annexure* to be completed by the claimant's treating specialist.
- Sanlam will request further medical information/documents if required.

The claimant can only claim for the illnesses listed in his/her contract.

General

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

The employer must either post, fax or e-mail the duly completed forms to:

Sanlam Group Risk: Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532
Fax number (021)947-3207
E-mail address Disabilityclaimbenefits.EB@sanlam.co.za

Sanlam

Critical/Severe Illness Claim:
Declaration by fund/scheme

Particulars of fund/scheme

Name of fund/scheme _____ Code _____

E-mail of contact person _____ Telephone number _____

Postal address _____

_____ Postal code _____

Name of branch/participating employer _____

Particulars of the member/insured

Full first names and surname _____

Date of birth ___/___/_____ Gender _____ Marital status _____

Occupation _____ Identity number _____

What illness or claim event stipulated in the policy is being claimed for? _____

Particulars of membership

Membership no _____ Pay-sheet no. (If any) _____

Date of entering service ___/___/_____ Date of permanent appointment ___/___/_____

Date of commencement of membership ___/___/_____ *(dd/mm/ccyy)*

Annual pensionable remuneration of member		Date granted
i. On fund/scheme anniversary before critical/severe illness incident:	R	/ /
ii. On date of critical/severe illness incident	R	/ /
iii. One year immediately before critical/severe illness incident	R	/ /

If (ii) differs from (i), state the date of the increase. _____

Did the member/insured qualify for membership of the fund/scheme on the date of commencement of critical/severe illness? Yes ☐ No ☐

Signature on behalf of the fund/scheme

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

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

Signature _____ Designation _____

Signature _____ Designation _____

Statement by insured for Critical/Severe Illness claim

Name of fund/scheme _____

Name of insured _____

Insured's date of birth _____ *(dd/mm/ccyy)* Telephone number _____

Membership number _____ Cell Phone number _____

Identity number _____ E-mail address _____

Medical history

1.1 Name, address and telephone number of your regular family doctor.

_____

_____

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

1.3 Date of last consultation ___/___/___ *(dd/mm/ccyy)*

1.4 Who was your previous family doctor? _____

Nature of claim and particulars of consultations

1.5
- For which 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 for the first time? ___/___/___ *(dd/mm/ccyy)*
- State the initials, surname, address of the doctor whom you consulted, as well as the telephone number.

_____

_____

1.6 Please state the details of the doctors, specialist and date of consultations 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 ( ) _____

Nature of claim and particulars of consultations *(continued)*

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

1.7.1 Date of accident ____/____/____ *(dd/mm/ccyy)*

1.7.2 Circumstances causing the accident.

_____

_____

_____

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

_____

_____

_____

General

Do you have critical/severeillness assurance with other companies too? Yes ☐ No ☐

If so, Name of 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

Name of account holder _____

Postal address _____

_____ Postal code _____

Residential address _____

_____ Postal code _____

E-mail address _____

Telephone number(s) (work) _____ (home) _____

If the benefits are to be paid into the beneficiary's bank account, please provide us with a copy of a bank statement not older than three months as well as the following information:

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account Cheque/current ☐ Savings ☐ Transmission ☐

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 Sanlam to:

- obtain from any person whom I hereby so authorise and request to give any information which Sanlam 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 Sanlam or by the operators of such database.

Signature

Witness _____ Signature _____

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

Questionnaire for medical practitioner/ doctor: Critical/Severe Illness

Name of fund/scheme _____

Membership no _____

Name of branch/participating employer _____

Name of claimant _____

Insured's date of birth ____/____/____ *(dd/mm/ccyy)* Identity number _____

Dear Medical practitioner /Doctor

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

A General *(To be completed at all times)*

Are you the insured's family doctor? Yes ☐ No ☐

- If "Yes", from which date is the claimant your patient? _____ *(dd/mm/ccyy)*
- If "No", please give his/her name, if known to you.

_____

What is the illness or claim event of the claimant and complications, if any?

Illness or claim event	Complications

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

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

Please state the name and address of any **other** Medical practitioner/doctor the insured consulted and the contact details.

Medical practitioner/Doctor	Address	Nature of illness	Contact details

Date on which illness was diagnosed / Date of the loss / Date of the incident ____/____/____ *(dd/mm/ccyy)*

Date of first consultation ____/____/____ *(dd/mm/ccyy)*

B Claim Requirements: Guidelines for Critical / Severe Illness insurance

Cancer and Tumors		
All CANCERs (Stage I to IV) All brain tumors All benign endocrine tumors Amyloidosis	* Up to date clinical report from the treating medical specialist, including all of the following: 1. Latest staging of disease; 2. Pathology report(s); 3. Surgical procedures where performed; 4. Treatment plan.	
* Basic requirements and the following cancers will need additional requirements for consideration:		
All chronic lymphocytic leukamias	As above PLUS	Rai Classification of disease
All lymphomas	As above PLUS	Ann Arbor Classification of disease
All myelomas	As above PLUS	Durie-Salmon scale classification
All prostate cancers	As above PLUS	Gleason scoring

Cardiovascular Conditions	
Heart attack	1. Clinical report including date of diagnosis, extend of infarction (transmural or sub-endocardial); 2. Copy of all ECG's available (i.e. old and new); 3. Serial Cardiac enzymes (CK, CK-MB fraction) – copy of lab reports; 4. Cardiac markers (e.g. trop T); 5. Other: Reports of echocardiogram, angiogram. *If impaired ejection fraction:* 1. A repeat of Echocardiogram 6 weeks later.
Coronary artery bypass graft (CABG) & angioplasty	Cardiologist's report; and Operation report
Cardiomyopathy	Up to date cardiologist report, including all of the following: 1. Echocardiogram(s) with the ejection fraction; 2. Effort ECG, where possible, w.r.t. to METS reached; 3. Comment on whether maximum medical improvement has been reached; 4. All other relevant report(s).
All rhythm abnormalities	1. Cardiologist's report; 2. Copies of ECG or Holter tracing reports; 3. Operation report regarding pacemaker, defibrillator or ablation.
All structural defects and structural diseases of the heart	1. Cardiologist's and or cardiothoracic surgeon's report; 2. Operation report
All vascular conditions of neck and brain	1. Specialist detailed report including treatment and response; 2. Operation report(where performed); 3. Copies of all vascular studies done (e.g. Doppler studies, angiography, CT or MRI); *In addition*: For stroke – A Specialist Physician assessment after maximal medical improvement.
All conditions and diseases of the aorta and major vessels	1. Specialist's (cardiologist/cardiothoracic surgeon/ physician) report; 2. Copies of angiography and all laboratory tests must be included; 3. Operation report (where applicable).
All peripheral conditions or diseases	1. Vascular surgeon's report; 2. Operation report (where applicable); 3. Copies of all vascular studies done (e.g. Doppler studies, angiography, CT or MRI).
Primary pulmonary hypertension	Specialist physician's report confirming the diagnosis. Report must include the following: 1. NYHA rating; 2. All copies of mean pulmonary artery pressures.

Central Nervous System	
For all neurosurgical procedures	1. Neurosurgeon report; 2. Operation report.
For status epilepticus with neurological impairment	1. Specialists report; 2. Copies of all EEG's; 3. Copies of all drug serum levels; 4. Detailed clinical records of 12 months or more.
For Guillain-Barré syndrome	Specialists' report. *Detailed clinical record must include the following:* 1. All records of assisted ventilation; 2. Impairment assessment after 6 months.
For all neurological impairments	Neurosurgeon's or neurologist's report including 1. Detailed neurological assessment of any impairments including assisted ventilation records; 2. Operation report where appropriate; 3. Copies of all radio-imaging.
All motor diseases	1. Neurologist's detailed report; 2. Lab blood results; 3. Copies of all nerve conduction tests; 4. Radio-imaging results; 5. Assessments of ADL's.
Coma	1. Specialists' report including neurological impairment noted; 2. Detailed clinical record of assisted ventilation including records of serial GCS screening.
Cognitive impairment	1. Specialist's detailed report (i.e. must include copies of all testing to exclude other causes); 2. Copies of all radio-imaging; 3. Assessment of ADL's.
Multiple sclerosis	1. Detailed reports from neurologist (with respect to diagnosis, also a confirmatory report by 2nd neurologist); 2. Particular attention to the type of neurological deficits, date of onset and its/their permanence, where relevant; 3. Radio-imaging reports.

Connective	
Scleroderma, Polyarteritis nodosa, Wegeners, Sarcoidosis	1. Copies of all laboratory tests, biopsy finding and imaging; 2. Details of all organ involvement with documented evidence.
Rheumatoid Arthritis	Rheumatologist report, and must include the following: 1. Blood tests (Rheumatoid Factor); 2. Details of joint involvement(all affected joints to be listed, all x-ray copies); 3. Detailed full treatment history and response to treatment, to date.
Systemic lupus erythematosus (SLE)	Clinical report by rheumatologist, including 1. Qualifying diagnostic criteria; 2. All blood tests; 3. Organ involvement and evidence of this.

Ears	
Detailed clinical report by ENT	Must include 1. Treatment history; 2. Copies of all audiograms and scans. *Where applicable, the following also:* Operation report; 1. Acoustic reflex testing report; 2. Balance testing report

Gastrointestinal (Git) Disorders	
All conditions	Specialist's report, must include the following: 1. Biopsy reports; 2. Operation report or evidence of inoperable condition; 3. Treatment history *In addition:* For liver disorders – Staging of disease using Child-Pugh ratings.

Infections	
Human immunodeficiency virus (HIV)	Needle-stick Injury: 1. Specialist reports; 2. Copies of injury on duty notification; 3. Copies of Initial HIV and follow up HIV test; 4. Copies of date of submission of informing the insurer (client directly). *Clinical manifestation of Aids:* 1. Specialist report; 2. Serial CD4 counts while on treatment; 3. Detailed treatment history; 4. Classification of disease according to World Health Organisation (WHO) staging for HIV infection.
Malaria	1. Detailed specialist report noting impairment as well, to be completed 3 months after event; 2. All serology of parasite count.
Bacterial meningitis	1. Detailed specialist report 2. Copies of all serology and special investigations.
Loss of bowel or bladder function	1. Specialist report with detailed history of traumatic event; 2. Copies of radio-imaging.

Injuries / Accidents	
All Burns	Specialist report with full details on degree of burn and affected body areas (according to standardised scale, e.g. Lund and Brower Chart)
All Fractures	1. Specialist report with detailed history of traumatic event; 2. Copies of all x-ray and scans; 3. Operation report (where applicable).
Coma, assisted ventilation	1. Specialists' report including neurological impairment noted; 2. Detailed clinical record of assisted ventilation including records of serial GCS screening.
Spinal cord injuries	1. Specialist report with detailed history of traumatic event; 2. Copies of radio-imaging.
Abdominal trauma	1. Specialist report with detailed history of traumatic event; 2. All operation reports
Trauma with nerve injury	1. Specialist report including details of traumatic event; 2. Copies of all neurophysiological tests.
Animal Bites	*Dog bites:* 1. Specialist report including details of traumatic event; 2. Copies of all neurophysiological tests. *Snakebites:* 1. Detailed clinical report by specialist; 2. Copies of all blood tests; 3. Hospital records.
Poison	1. Detailed clinical report by specialist; 2. Copies of all blood tests; 3. Hospital records.

Lymph and Blood	
For all blood disorders:	1. Specialist's report. 2. Detailed treatment reports: including clinical record of all blood transfusions with dates, no. of units; 3. Haematology lab results; 4. Operation reports (where applicable). *In addition:* For diffuse Intravascular clotting – Scoring according to International Society on Thrombosis and Haemostasis (ISTH).

Musculoskeletal	
For loss of use of any limb or part of limb:	1. Medical report; 2. Detailed documented evidence of degree of affected body part /limb function. *(Each limb should be assessed individually)*
For infection of long bone or joint:	1. Orthopaedic surgeon's report; 2. Copies of all x-ray or scan reports; 3. Biopsy reports and or laboratory results of fluid analysis and culture; 4. Detailed treatment history.
For nerve repair after complete severance	1. Surgeon's or neurosurgeon's report; 2. Operation report.
For Paget's disease of the bone:	1. Specialists report; 2. X-ray reports; 3. Copies of all diagnostic tests performed.

Renal Disorders	
All Diseases and vascular events of the renal system	1. Nephrologist report; 2. Lab, serology results; 3. Biopsy / radio-imaging results.
All surgical conditions	1. Surgeon or nephrologist's report; 2. Operation report.
Impaired function	1. Nephrologist report; 2. Lab serology results; 3. Must include urine analysis and serial GFR measured regularly over 12 months or more; 4. Dependence on dialysis to be noted.

Respiratory Disorders	
All chronic respiratory diseases and respiratory impairment	1. Pulmonologist report; 2. Serial records (>3) of FEV1/; FVC or DCO.
Interstitial lung disease	1. Pulmonologist report; 2. Radio-imaging report; 3. Biopsy results.
Severe status asthmaticus	1. Specialists' report; 2. Detailed clinical record of assisted ventilation.
Pulmonary embolism	1. Specialists' report; 2. Detailed clinical record of assisted ventilation. Recurrent pulmonary embolism, with associated pulmonary hypertension (mean pulmonary artery pressure) > 40mmHg: 1. Specialist report including treatment; 2. Copies of all pulmonary arterial measurements.
All surgeries of the lung(s)	1. Specialist report; 2. Operation report.

Urogenital Disorders	
For all urogenital disorders Male and Female	1. Specialist report; 2. Operation report.

Vision	
Diseases of the eye	1. Ophthalmologist's report. 2. Copies of all ophthamologic tests
Surgical Conditions/Trauma of the Eye	1. Detailed ophthalmologist's report. 2. Copies of all ophthamologic tests. 3. Operation report, where applicable
Loss of Vision	1. Ophthalmologist's report. 2. Copies of all ophthamologic tests including visual acuities. 3. Brain scans, where applicable

Catch-All	
General	Detailed medical report with full details with regarding permanent impairment. All supporting documents to be included.
Terminal illness	Detailed medical report with full details with regards terminal illness. All supporting documents to be included

Information and signature for Medical practitioner/Doctor

Initials and surname _____

Practice number _____ Qualifications _____

Address _____

_____ Postal code _____

Telephone number (home) _____ (work) _____

Signature _____

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