CRITICAL ILLNESS BENEFIT CLAIM FORM – CLAIMANT & EMPLOYER

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or Postnet Suite 196, Private Bag X1, Melrose Arch, 2076
Tel: (011) 351 5000. Fax: (011) 351 3079. Email: hgrdisability@hollard.co.za

SECTION A: HOW TO CLAIM

Two forms are required for the submission of a critical illness claim.

1. CRITICAL ILLNESS CLAIM FORM – CLAIMANT & EMPLOYER (to be completed by the claimant and the employer)
2. CRITICAL ILLNESS CLAIM FORM – MEDICAL ATTENDANT'S REPORT (to be completed by the claimant/employer and the medical attendant)

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family. In the event that the claimant is incapacitated, the sections to be completed by the claimant must be completed by the claimant's caretaker and/or the employer. We require an affidavit confirming the claimant's inability to complete and sign the claimant's personal declaration.

It is essential that both forms are fully completed to prevent any unnecessary delays due to missing or incomplete information. It is the employer's responsibility to compile all the documents required and to submit them to Hollard Life. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in nine sections:

- Section A: How to claim (informative section)

To be completed by either claimant or employer or both:

- Section B: Policy details
- Section C: Employer's details
- Section D: Claimant's personal details

To be completed by claimant:

- Section E: Claimant's report on diagnosis of critical illness
- Section F: Banking details
- Section G: Declaration

To be completed by employer:

- Section H: Employer's report
- Section I: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the claimant's identity document
- a copy of the claimant's payslip for the last completed month of employment
- proof of banking details (cancelled cheque or bank statement)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information as well as your privacy. If necessary, we may need to share either your and/or the insured's personal or medical information, or both, with third parties. These third parties are other insurance and/or reinsurance companies, or service providers that may assist us in assessing and managing the risk or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal and medical information, and signing this form, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties. We will treat this information with caution and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

SECTION B: POLICY DETAILS (to be completed by employer or claimant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS (to be completed by employer or claimant)

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

Email address:

SECTION D: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant)

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cell phone number:

Email address:

Occupation:

SECTION E: CLAIMANT'S REPORT ON DIAGNOSIS OF CRITICAL ILLNESS (to be completed by claimant)

1. What critical illness have you been diagnosed with?

2. What is the date of the diagnosis? D D M M Y Y Y Y

3. Who is the medical attendant who made the diagnosis?

Telephone number

4. Have you previously received any benefits from any other insurance company? Y N
If "Yes", please provide details:

SECTION F: BANKING DETAILS (to be completed by claimant)

Payment will be made to the claimant only.

Name of account holder:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

SECTION G: DECLARATION (to be signed and dated by claimant)

I, hereby declare that I am the person insured under the policy mentioned above.

The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. I agree that all the written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that Hollard Life reserves the right to proceed with the appropriate action against the claimant as well as any beneficiary or third party that received a benefit (if applicable).

Accepting that I am thereby limiting my right of privacy, but to assist with the assessment of my claim I irrevocably authorise Hollard Life:

a) to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Life deems necessary, and
b) to share with other insurers that information and any information contained in this claim form or in any related 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 Hollard Life or by the operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information Hollard Life may require relating to my medical history, my injury, my employment history and/or any other information which may be necessary for Hollard Life's consideration of the claim. I also provide consent that any information provided by me may be verified against other sources or data bases including credit bureaus. Furthermore I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at ____ on this ____ day of ____ 20 ____

Claimant's name | Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name | Signature

Identity Number of Caretaker:

Telephone number of Caretaker:

Email address of Caretaker:

OR

Name and Surname of authorised signatory who warrants His/her authority to sign on behalf of the employer: | Signature

Identity Number of authorised signatory:

Designation of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

SECTION H: EMPLOYER'S REPORT (to be completed by employer)

1. When did the claimant join the company? D D M M Y Y Y Y

2. When did the claimant join the critical illness benefit scheme? D D M M Y Y Y Y

M M Y Y Y Y

3. Month last risk premium was paid for?

4. What was the claimant's salary as at the date of the diagnosis of the critical illness? R

5. What was the effective date of this salary? D D M M Y Y Y Y

SECTION I: DECLARATION (to be signed by employer)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at _____ on this _____ day of _____ 20 _____

Name and Surname of authorised signatory who warrants his/her authority to sign on behalf of the policyholder

Designation

Signature
For and on behalf of the policyholder

Company Stamp

Identity Number of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.