Claim for a Sickness benefit

Contact details:

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 8 and 9 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) _____ _____ _____
_____ _____ _____

Surname _____

Full first names _____

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

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

Passport 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)*

Income office _____

Income tax number _____

Plan number(s) _____

Nature of claim and particulars of consultations

Your current full-time occupation _____

How much time of the day do you spend on:

Administration ☐ % Supervisory ☐ % Walking and Standing ☐ % Travel ☐ % Physical duties ☐ %
(Total must amount to 100%)

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)*

Medical Scheme Details

- Name of medical scheme provider _____
- Medical scheme member number _____
- Are you the principal member of this medical scheme? Yes ☐ No ☐

  If "No", please state the name of the principal member _____

Declaration of Principal member of the medical scheme

I irrevocably authorise my medical scheme to provide Sanlam Life with any information pertaining to the medical scheme records,that may be required.

Signature of Principal member of medical scheme _____ Date _____

Plan number(s) _____

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
	/ /	( )	( )	
	/ /	( )	( )	
	/ /	( )	( )	
	/ /	( )	( )	

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)*

Plan number(s) _____

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. Details of account holder/plan holder

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ 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(s) _____

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.

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ 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.

Or

Plan number(s) _____

Payment to cessionary *(continued)*

I hereby give permission for the cession to be cancelled.

Name of contact person _____ Contact number: ( ) _____

Signature of cessionary _____ Official stamp of institution _____

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, _____ *(first names and surname of the plan holder),*

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/Zip code _____

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

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Plan number(s) _____

Proxy and/or payment to a third party *(continued)*

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

Source of funds _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ 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 plan holder _____ 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 or any other stakeholders for the purposes of assessing, investigating, processing or any other reason including prevention of fraudulent claims that information and any information contained in this plan 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:

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) _____

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

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 _____