Claim for accident benefit

1 Contents

The following forms must be completed for the submission of a claim for a accident benefit.

- **Accident claim: Declaration by fund/scheme** - To be completed by empolyer
- **Statement by insured for accident benefit** – To *be completed by the insured.*
- **Confidential medical report** - *Report to be compiled by insured's treating specialist according to the "Minimum format for the medical report in respect of a accident benefit claim" attached. (See page 5).*

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

2 General

- The insured has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost. It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.
- The insured is obliged to submit whatever medical or other information Sanlam may reasonably require.

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

Sanlam Corporate: Group Risk - Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532

Fax number (021)947-3207
E-mail address EBDisabilityClaimsBenefits@sanlam.co.za

Accident claim: Declaration by fund/scheme

A. Particulars of fund/scheme

Name of fund/scheme _____ Code _____

Name of branch/participating employer _____

E-mail address _____

Telephone number ( ) _____

B. Personal details of the insured

Full names and surname _____

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

Marital status Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Identity number _____ Occupation _____

Particulars of membership

Membership no. _____ Paysheet number (if available) _____

Date of entering service _____ *(dd/mm/ccyy)* Date of permanent appointment _____

Date of comencement of membership _____ *(dd/mm/ccyy)*

Annual pensionable remuneration of insured		Annual salary (R)	Date granted *(dd/mm/ccyy)*
(i)	On fund/scheme anniversary before date of a accident		
(ii)	On date of accident		

Sum insured in respect of accident benefit. R _____

Date of the last deduction of insured's contribution. _____ *(dd/mm/ccyy)*

Employer's contributions in respect of the member/insured was paid/will be paid up to: _____ *(dd/mm/ccyy)*

Have contributions in respect of the member/insured been paid regularly and up to date? Yes ☐ No ☐

C General

1. Did/was the member/insured on the date of his/her accident:
   - Qualify for membership of the fund/scheme? Yes ☐ No ☐
   - A member of the fund/scheme? Yes ☐ No ☐
2. Benefits must be made payable to: ☐ Fund/scheme ☐ Member/Insured
3. Please attach the following document:
   - Copy of member's birth certificate or identity document.

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

Signed on behalf of the fund/scheme

Signature _____ Designation _____

Signature _____ Designation _____

Place _____

Date _____ *(dd/mm/ccyy)*

Statement by insured for an accident benefit claim

1 General detail

Name of fund/scheme _____

Name of insured _____

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

Identity number _____

Telephone number ( ) _____ Cell phone number _____

E-mail address _____

2 Nature of disability and medical care

2.1 Name and address of your regular family doctor.

_____

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

2.3 Mention date of last consultation. _____ *(dd/mm/ccyy)*

2.4 Please provide the names of all doctors, specialists and hospitals that you have consulted in this regard since the accident.

Name of doctor/hospital	Address and telephone number	Date	
		From *(dd/mm/ccyy)*	**To** *(dd/mm/ccyy)*

2 Nature of disability and medical care *(continued)*

2.5 Please describe the circumstances causing the accident.

2.6 If a formal inquiry was conducted, please state by whom and what the result was.

2.7 Date of accident _____ *(dd/mm/ccyy)*

3 Income

Are you receiving or do you expect to receive, as a result of your accident, any benefit, salary, pension or compensation of whatever nature? (This includes income from any employer, partner, assurance company, a pension or retirement annuity fund, any governmental fund or any other source.)

If "Yes", please give the following details:

Regular amounts (including life annuities)

Source of benefit	Amount (R)	Commencement date of payment *(dd/mm/ccyy)*	Date of cessation *(dd/mm/ccyy)*

Disability amounts included in ordinary insurance at any other insurer (regardless of whether a claim has been submitted already).

Name of company	Amount (R)	Date of payment *(dd/mm/ccyy)*

4 Payment of benefits

4.1 **Contact details**

Postal address _____

_____ Postal code _____

Residential address _____

_____ Postal code _____

Telephone number ( ) _____ Cell phone number _____

4.2 **Bank details**

Name of bank _____ Name of branch _____

Account number _____ 6-digit bank code _____

Type of account Cheque ☐ Savings ☐ Other *(specify)* _____

Important:
If the benefits are to be paid into your bank account, please provide us with a cancelled cheque or a certified deposit slip in the case of a savings account.

4.3 **Tax particulars**

- Income tax reference number _____
- Income tax office to which last return was rendered _____

5 General

Please give any other information which, in your opinion, may influence the claim.

Premium payments must continue until claim, if any, is admitted.

Declaration

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.
- 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 data base.

Signature _____

Witness _____

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

Minimum format for the Medical report in respect of an accident benefit claim

Particulars of member/insured

Initials and surname

Date of birth

Accident details

Before you perform the examination, please determine the insured'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.

Please supply us with a report in accordance with the guidelines set out underneath after you have examined the insured.

The insured is responsible for the costs relating to this consultation and medical report. Should you require additional investigations, these will also be for the account of the insured.

1. Date of accident.
2. Occupation of claimant.
3. Please state bodily loss that was suffered. (Provide copies of all specialist's reports, and/or X-rays in your possession)
   - 3.1 If the use of the hand(s) or foot/feet or a combination of these was suffered, please provide the following information:
     - The clinical diagnosis and prognosis.
     - Describe the remaining function of the hand(s) and/or foot/feet and toe(s) and finger(s) in respect of movement, power and sensation.
     - If applicable, indicate the amputation levels by means of a sketch.
     - Describe the neurological handicap, where applicable.
   - 3.2 If the loss of the use of the eye(s) was suffered, please provide the following information and the latest tests:
     - The clinical diagnosis and prognosis.
     - Vision acuity test, if relevant.
     - Eye movements, where applicable.
     - Test of field vision, if possible.
   - 3.3 If the loss of the use of the ear(s) was suffered, please provide the following information and the latest tests:
     - The clinical diagnosis and prognosis.
     - Audiogram.
4. When did the physical loss take place?
5. Are you the claimant's regular doctor?
   - 5.1 If not, please provide the family doctor's name and telephone number.
   - 5.2 If so, please provide information and dates of any relevant illness or injuries about which you were consulted.
6. If you were at any stage aware of excessive use of alcohol, please provide full information. (Please indicate by whom and where the claimant was treated.)