

Protection of Personal Information Disclosure

Why Personal Information is required: Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:

- underwriting and providing accurate and effective insurance cover and related value-added services;
- member communication;
- market research and statistical analysis;
- verification of the personal information provided;
- to comply with all legal and regulatory requirements, including applicable codes of conduct;
- to protect Sanlam Life's interests; and
- any purposes

Failure to provide the mandatory information will prejudice your insurance cover.

Changing and correcting Personal Information: You have the right to:

- Request a copy of your personal information as processed by Sanlam Life;
- Ask for an update and/or correction of your personal information;
- Lodge a complaint with the Information Regulator.

Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.

Other parties that may receive the Personal Information:

- We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so.
- We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.

For more information, please refer to the [Sanlam Group Privacy Notice](#).



Claim for accident benefit

1 Contents

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

- **Accident claim: Declaration by fund/scheme** - To be completed by employer
- **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 an accident benefit claim" attached. (See page 6).

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 commencement 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 an 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 benefits4.1 **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, _____ (full name(s) and surname of insured)
(Identity number) _____ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess (and review) my disability. This includes my previous medical history as well as any psychological or psychiatric records for the purpose of determining my ability to perform work.

I also declare that I have no objections to my medical information being supplied to and obtained from, either directly or through a data base operated by or for insurers as a group, Sanlam's medical advisor, the employer, fund, ombudsman, legal representatives, other insurers, reinsurers and/or the medical service providers involved in the disability assessment and rehabilitation processes if necessary, for the purposes of underwriting risks or assessment and review of any claim for benefits under a policy.

I also irrevocably authorise any medical practitioner, medical specialist, health professional, hospital, medical scheme, or any other person or institution who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I accept and understand that I am limiting my right to privacy to the extent permitted by me in this authorisation, to facilitate the validation and assessment (and review) of my disability claim under the group insurance policy, or any other reason including detection and prevention of fraudulent claims. I acknowledge that I cannot cancel this authorisation and that it will endure even after my death.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

I declare that I am the person described above and that the replies given to the questions are true and correct.

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.)