



## Claim for Trauma / Dread disease

Please return the completed form to: **Living Benefit Claims**

Postal address PO Box 1, Sanlamhof 7532 Telephone number (021) 916-3455  
 E-mail address livingbenefits@sanlam.co.za Fax number (021) 947-5804

For Namibian policies refer to: claims.affluentsupport@sanlam.com.na or contact our Sanlam Namibia office at +264 61 294 7440.

### Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.
- It is also important that you should be aware of the implications of the non-payment /payment of this claim for your financial position. We therefore strongly recommend that at this stage you should already 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 per post. If readable copies of documents are provided to us, the original documents are unnecessary.

### Please supply the following documents:

- A copy of your identity document
- Copies of all specialist reports in your possession as well as copies of all special and laboratory tests. You are responsible for the costs relating to this medical information.
- Sanlam will request further medical information/documents if required.

You can only claim for the illnesses listed in your own contract.

### 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)

### Nature of claim and particulars of consultations

- For what 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? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (dd/mm/ccyy)

Plan number(s) \_\_\_\_\_

- State the initials, surname, address of this doctor, as well as the telephone number.

\_\_\_\_\_  
 Telephone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_

**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)

**Details of doctors, specialists and consultations you consulted 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 ( ) \_\_\_\_\_

**Other Trauma/Dread disease insurance**

Trauma / Dread disease insurance at other insurers (irrespective of whether a claim has been submitted):

Name of insurer	Plan- / Reference number	Sum insured (R)	Cessation date (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 \_\_\_\_\_

Issuing 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 / Business 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 \_\_\_\_\_

Issuing 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 / Business 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 \_\_\_\_\_

Issuing 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 / Business 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)