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Sanlam Risk Benefits

2738E

Claim for Accident benefit / Physical Impairment benefit / Functional Impairment benefit / Impairment benefit

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.

This is a generic claim form. Please indicate below for which benefit you are submitting a claim and take note of the requirements for the specific benefit claim.

I submit a claim for: Accident benefits ☐ Physical Impairment benefits ☐ Functional Impairment benefits ☐ Impairment benefits ☐

Plan number(s) _____

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 understand 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 note: A claim can only be submitted for the claim events as stipulated in the contract, on all the above-mentioned benefits.

Accident benefits / Physical Impairment benefits

Please supply the following documents:

- A copy of your identity document
- Report according to the Minimum format of report regarding Accident/Physical benefit claims. (This forms part of this claim form and must be handed to the treating doctor/specialist physician to compile.)
- SAPS report or Injury on duty report regarding the accident.
- If the claim reason is burn wounds, then also complete the form **Engburns** (Annexure Burnwounds) on which the extent of the burns should be indicated by the doctor.
- If the claim reason is amputation, then also complete the form **Enghandleft** (Draft of hand left) or **Enghandright** (Draft of hands right) on which amputation should be indicated by the doctor.

Functional Impairment benefits / Impairment benefits

Please supply the following documents

- A copy of your identity document.
- Report according to the Minimum format of report regarding impairment benefit claims. (This forms part of this claim form and must be handed to the treating doctor/specialist physician to compile.)
- Copies of all available medical reports, X-rays, MRI scans and special medical tests done.
- SAPS report or reports of injury sustained at work if a claim was caused by an accident on duty, as well as the result of the investigation if already finalised.

Plan number(s) _____

Particulars of insured life

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 ☐

Current main occupation _____

Since when have you been engaged in this occupation? _____ (dd/mm/ccyy)

Race White ☐ Asian ☐ Coloured ☐ Black ☐ Unknown ☐ (For statistical purposes)

Nature of claim and particulars of consultations

- For what contractual listed illness, injury or deviations do you claim?

_____

_____

- Describe the loss which you are experiencing as a result of the accident when the loss occurred.

_____

State from which date the loss was experienced. _____ (dd/mm/ccyy)

- On which date did you consult a doctor regarding these symptoms for the 1st time? _____ (dd/mm/ccyy)
- State the initials, surname, address and telephone number of this doctor:

_____

_____

Telephone (work) (____) _____ Fax (work) (____) _____

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)
- Provide the following information with regard to all other doctors/specialists you have consulted regarding the condition that caused the claim.

Plan number(s) _____

Medical history (continued)

Details of doctors, specialists and consultations

Name and surname	Type of specialist	Address	Telephone number	First consultation (dd/mm/ccyy)
			( )	
			( )	
			( )	
			( )	

Public Healthcare

Name of hospital	Name of Specialist	Patient number	Telephone number	First consultation (dd/mm/ccyy)
			( )	
			( )	
			( )	
			( )	

Accident particulars

- Date of accident _____ (dd/mm/ccyy)
- Place of accident _____
- The disability was caused by ☐ Motor vehicle accident ☐ Accident at home ☐ Accident at work ☐ Shooting accident ☐ Other (specify) _____
- Give a brief description of how the accident happened:

  _____

  _____

  _____

- If there was an investigation into the cause of the accident, provide the following:

  Name of police station _____

  Case number _____

  Initials and surname of investigating officer _____

  Contact details Telephone number (____) _____ Fax number (____) _____

  Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report):

  _____

  _____

- Did you suffer any physical loss? Yes ☐ No ☐

  If “Yes", describe the nature of the loss you suffered.

  _____

  If the loss did not happen on the date of the accident, please state the 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:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐

Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐

Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐

Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐

Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐

Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

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:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐
Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐
Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐
Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐
Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐
Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

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:

Body Corporate ☐ Charitable Organisation ☐ Church/Religious Organisation ☐ Closed Corporation ☐

Club ☐ Deceased Estate ☐ Foreign Government ☐ Foreign Listed Company ☐ Foreign State Owned Entity ☐

Foreign Trust ☐ Foreign Unlisted Company ☐ Foundation ☐ Fund ☐ Insolvent Estate ☐

Listed Company ☐ Medical Schemes ☐ Non-Government Organisation ☐ Non-Profit Organisation ☐

Other Corporate Arrangement ☐ Retirement Fund ☐ School/University ☐ State Owned Enterprise ☐

Stokvel ☐ Trade Union ☐ Trust ☐ Unlisted Company ☐

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)

C. Lump Sum Conversion Option (if applicable)

This rider benefit will provide a client who is totally and permanently occupationally disabled or 100% impaired, the option to convert their future income payments to a lump sum amount. It also guarantees the period for which the income will be paid if they were to die within this period.

Please tick the appropriate box

Should my claim be approved, I hereby confirm that:

I choose the lump sum conversion option ☐

I choose the monthly instalment option ☐

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)

Plan number(s) _____

Minimum format for compiling a report

Accident / Physical Impairment benefit claim

In support of a claim of the accident benefits of the plan/plans _____ _____

on the life of _____ born _____ (dd/mm/ccyy)

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

To consider the claim, we require a report containing the information below in respect of the specific loss/injury that the claimant suffered. The claimant will bear the cost of the report. Sanlam Life has the claimant's permission to disclose the information.

Guidelines: Medical report (This list is a guideline only)

1. The date of the accident.
2. Diagnostic code (ICD - 10) (only) for primary diagnosis
3. The occupation of the claimant.
4. When did the physical loss take place?
5. If you are the claimant's regular doctor.
   - If not, please provide the family doctor's name and telephone number.
   - If so, please provide information and dates of any relevant illnesses or injuries about which you were consulted.
6. If you are at any stage aware of excessive use of alcohol, please provide the full information.
7. If the claimant was ever tested for HIV antibodies. If so, what the result was.
8. The benefits will only be payable for the loss of use of certain limbs, the amputation thereof or certain other injuries/illnesses stipulated in the contract. Please state the bodily loss/injury sustained and compile a clinical report according to the following requirements/guidelines per loss/injury. (Please provide copies of all specialist reports, and/or x-rays in your possession.

   Vision loss
   - Vision acuity pre- and post-correction
   - Visual field where applicable

   Hearing loss
   - Audiogram with speech discrimination

   Burns
   - Indicate the areas of third degree burn wounds on attached sketch

   Coma
   - The Glasgow Coma scale from admission to discharge
   - Periods of ventilation and intravenous need to be indicated. (Specify dates)
   - Medication administered during the period of the coma.

   Amputation
   - Sketches indicating the level of amputation

   Paraplegia and Quadriplegia
   - Diagnosis and clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)

   Penetrating gun-shot wounds and stab wounds
   - Operation report

   Fractures : (ribs/pelvis/spine)
   - Radiological reports
   - Neurological impairment with spine fractures

   Loss of bowel or bladder function
   - Only the clinical report
   - Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological impairment

   Post-traumatic fat-embolism
   - Report of ventilating/perfusion (VQ) scan

   Liver and spleen rupture
   - Operation report

Functional impairment / Impairment benefit claim

Important
This report must be compiled by a specialist and not a general practitioner

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

The insured has required us to consider whether he/she qualifies for a claim.

To assist us in making a justified decision, we have to be provided with a report regarding the impairment of this person.

Please compile the report in accordance with the guidelines set out in the **Guidelines: Medical report on impairment** underneath after you have examined the person.

The insured is responsible for the costs relating to this consultation and medical report.

Guidelines : Medical report on impairment

Please use the following only as a guideline to compile your report.

- Diagnosis: (DSM IV for psychiatric conditions)
- Primary diagnosis
- Diagnostic code (ICD -10) for primary diagnosis
- Secondary diagnosis
- Diagnostic code for secondary diagnosis (ICD -10)
- Date: Of the onset and course of disease
- Severity: Perpetual factors, secondary gain
- Current clinical findings: Describe in detail
- Treatment:
  - Treatment modalities
  - Duration of treatment
  - Rehabilitation
  - Types of medication and dosage
  - Therapeutic procedures
  - Hospitalisation
- Response to treatment
- Complications that is permanent
- Special investigations: e.g. ECG, X-rays, scans, blood tests done ect.
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability

Special requirements:

• Cardiovascular	NYHA-classification, exercise capacity, stress-ECG, ejection fraction, other
• Respiratory	Dyspnea-grading (ATS), exercise capacity (METS or VO2 max.), vitalogram pre- and post-inhalation (3 attempts), chest x-ray, single-breath diffusion test (DCO) in cases of interstitial lung disease.
• Orthopaedic	X-ray and stress views, MRI or CAT scans, other (e.g. nerve conduction tests)
• Psychiatric	Social functioning, concentration, psychometric tests in cases of cognitive impairment.