DISABILITY, CRITICAL ILLNESS OR DREAD DISEASE CLAIM FORM (TO BE COMPLETED BY CLAIMANT)

NEDGROUP LIFE

The issue of this form for completion does not imply admission of any liability by Nedgroup Life.
NB: This form must be completed before a commissioner of oaths.

SECTION 1

1.1 Policy number ID number

First name(s) and surname of claimant Age

First name(s) and surname of main member

Residential address
Line 1
Line 2
Suburb
Town
Province
Code

Tel (w) Cell Tel (h)

Email address

Name of contact person

Full postal address (if different from residential address)
Line 1
Line 2
Suburb
Town
Code

Income tax reference number Income tax office

Marital status ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other, eg common - law spouse

If other

If married ☐ Married in *COP ☐ Married out of *COP, excluding accrual system ☐ Married out of *COP, including accrual system ☐ Married under customary law ☐ Married under foreign law

Do you currently have any other disability benefits (including both lump sum and/or premium waiver, accidental benefits (loss of limbs, etc) or sickness policies either effected by you privately or provided under your pension scheme? If so, please give details below:

Company	Policy number	Type of policy	Amount of cover	
			Lump sum	Monthly income

1.2 Are you entitled to any other benefit occasioned by your disability from:

Your employer ☐ YES ☐ NO Amount R

The state ☐ YES ☐ NO Amount R

Other ☐ YES ☐ NO Amount R

1.3

1.3.1 What was your main occupation at the time of commencement of the disability?

1.3.2 Please describe your duties fully:

(*community of property)

1.4 What is the main focus of your work? (If a combination, indicate an estimated % split)

Handling objects/tools; operating	☐ YES	☐ NO	% split	
Interacting with people	☐ YES	☐ NO	% split	
Processing information (eg accounting)	☐ YES	☐ NO	% split	
Travel	☐ YES	☐ NO	% split	

1.5 Other occupation(s), if any

1.6 Name and address of employer at the time of the disablement:

Line 1

Line 2

Suburb

Town

Code

1.7 Nature of business:

1.8 What was your total taxable income in the 12 months preceding your disablement? R

NB: Deduct allowable expenses incurred in the production of your income.
Do not deduct any pension fund or retirement annuity fund contributions or medical expenses.

1.9 Skills training (on the job):

1.10 What school grade, academic, professional or trade qualifications do you possess?

2 MEDICAL HISTORY

2.1 General

2.1.1 Which injury or illness has given rise to this claim?

2.1.2 When did you first consult a medical practitioner in connection with this condition? d d m m y y y y

2.1.3 Have you had any similar or related illness or injury in the past? ☐ YES ☐ NO

If yes, give details:

2.1.4 Have you had any other illness or injury in the past? ☐ YES ☐ NO

If yes, give details:

2.2 Specific: Complete the applicable subsection(s) only.

2.2.1 If your health status has been changed by an illness, when was it first diagnosed? d d m m y y y y

How has it been treated? ☐ Medication ☐ Exercise ☐ Operations ☐ Other

If other, specify:

Nedgroup Life Assurance Company Limited .Reg No 1993/001022/06
1st Floor, Ridgeside Campus, 2 Ncondo Drive, Umhlanga Rocks, 4320; PO Box 149175, East End, 4018.
Tel 0860 263 543 Fax 0860 065 437 Website www.nedgrouplife.co.za.

2.2.2 If your health status has been changed by an injury, provide the date of the injury | d | d | m | m | y | y | y | y |

Cause of injury

How has it been treated? ☐ Medication ☐ Exercise ☐ Operations ☐ Other

If other, specify:

2.2.3 If the illness/injury has been caused by an accident or violent means, was it:

☐ Motor vehicle accident, ☐ an accident at work, ☐ an accident at home or ☐ other?

If other, specify:

When did it occur? | d | d | m | m | y | y | y | y | Was there an official enquiry? ☐ YES ☐ NO

If YES, by whom?

2.2.4 Has any legal action been taken? ☐ YES ☐ NO

If YES, by whom?

If appropriate, give the: Police station Police case number

SECTION 3 - HOSPITALISATION FOR SPECIAL INVESTIGATIONS OR TREATMENT

Repeat the information for **every** period in hospital.

Name of hospital	Date of admission	Date of discharge	Purpose
	d d m m y y y y	d d m m y y y y	
	d d m m y y y y	d d m m y y y y	
	d d m m y y y y	d d m m y y y y	
	d d m m y y y y	d d m m y y y y	

SECTION 4 - PRIVATE HEALTH SECTOR

4.1 Name of current general practitioner

4.2 Please state postal address

Line 1

Line 2

Suburb

Town

Telephone no (practice) Code

Period of consultation | d | d | m | m | y | y | y | y | to | d | d | m | m | y | y | y | y |

4.3 Name(s) of attending specialist(s)

Name	Type of specialist	Telephone number	Period of consultation

4.4 Name(s) of other health professional(s)/therapist(s) consulted

Name	Type of professional	Telephone number	Period of consultation

SECTION 5 - PUBLIC HEALTH SECTOR

5.1 Name of hospital ______ Patient reference number ______

5.2 Please state postal address

Line 1

Line 2

Suburb

Town

Code

5.3 Telephone no ______ Specialist department(s) ______

5.4 Period of consultation d d m m y y y y to d d m m y y y y

SECTION 6 - PRACTICAL IMPLICATIONS OF YOUR HEALTH CONDITION

Indicate only a specific change(s) in your ability to perform the following everyday tasks, and specify which symptoms caused the change(s):

6.1 Self-care, ie personal hygiene, eating, dressing, etc

6.2 Mobility, ie walking, sitting, standing, bending, carrying, etc

6.3 Use of public or private transport ☐ YES ☐ NO

6.4 Describe fully the nature of your disability:

Is the disability permanent? ☐ YES ☐ NO

6.5 Are you still under treatment? ☐ YES ☐ NO

If YES, please give the name and address of the doctor/specialist presently treating you:

6.6 Describe what treatment you have received for this disability:

6.7 What has been the result of this treatment?

6.8 What is your present condition?

6.9 Are you confined to: Bed? ☐ YES ☐ NO The house? ☐ YES ☐ NO

If neither, give details of your present activities:

6.10 Is any further treatment or operation contemplated? ☐ YES ☐ NO

If YES, please give details:

SECTION 7

7.1 How has your ability to follow your occupation been affected by this disability?

7.2 Current work status

- [ ] Still working
- [ ] On paid sick-leave
- [ ] On unpaid sick-leave
- [ ] Retrenched
- [ ] Under notice of termination of service

7.3 On what date were you last able to undertake any part of your occupational duties? | d | d | m | m | y | y | y | y |

7.4 On what date did you last actively engage in your occupation? | d | d | m | m | y | y | y | y |

If applicable, also the date of termination of service

7.5 Will you be able in the future to resume in whole or in part your occupation mentioned in 1.3 to 1.5? [ ] YES [ ] NO

7.5.1 If YES, when are you likely to be able to do so? | d | d | m | m | y | y | y | y |

7.5.2 To what extent?

7.5.3 If NO, please state what type of similar or other occupation you are likely to be able to follow taking into consideration your knowledge, training and abilities.

7.6 When are you likely to be able to commence a similar or different occupation? | d | d | m | m | y | y | y | y |

At what salary or income?

7.7 Employment history

Employer	Job title	Date appointed	Date and reason for leaving
		d d m m y y y y	
		d d m m y y y y	
		d d m m y y y y	
		d d m m y y y y	

7.8 Did any of the following contribute in any way to your disability?

7.8.1 Previous illness, injury, mental or physical defect [ ] YES [ ] NO

7.8.2 Hazardous occupation, pastimes or pursuits [ ] YES [ ] NO

7.8.3 Failure to seek timely and adequate medical attention or to heed medical advice given [ ] YES [ ] NO

7.8.4 Consumption of alcohol or the taking of drugs or narcotics (except under medical direction) [ ] YES [ ] NO

7.8.5 Violation of the criminal law, wilful or negligent exposure to peril or provoked assault [ ] YES [ ] NO

7.8.6 Attempted suicide or self-inflicted injury [ ] YES [ ] NO

If you answered YES to any of these items, please give full details or circumstances:

7.9 Medical aid details: Name of fund

Membership no

I hereby declare that I am the person insured under the aforementioned policy and that all particulars given are, to the best of my ability/knowledge, true and complete. I hereby authorise:

- any medical practioner, nursing home, institution or other medical authority to furnish Nedgroup Life with all such information as it may require in connection with my disability; and
- my employer(s) to furnish Nedgroup Life with all such information as it may require in connection with my occupation, including details of salary or income derived from my occupation.

Signature of claimant ______________________ Date d d m m y y y y

Residential address Line 1

Line 2

Suburb

Town

Code

Tel no

Signature of witness (Official of): ______________________

The above declaration was sworn to before me on d d m m y y y y

Commissioner of oaths Capacity

Only to be completed in cases where this policy is not ceded to a loan.

The release and discharge set out above is signed on the express understanding that it will be valid only if my claim is admitted by Nedgroup Life and the payment referred to therein is made.

Signed at ______________________ (place) on d d m m y y y y (date)

Signature

Signature

Witness

Witness