APPLICATION FOR PAYMENT OF A DREAD DISEASE CLAIM

CLAIM REQUIREMENTS:

1. Application for Payment of Dread Disease Claim form completed by claimant/ life assured
2. Medical Attendant Report form completed by regular family doctor (GP) providing full medical history for the period prior to policy commencement or reinstatement date
3. Copies of medical aid claim statements (if applicable)
4. Doctor's Statement completed by the life assured's treating specialist
5. All available reports and test results, such as histology reports; blood results; x-ray reports; CT/ MRI scan reports; ECG and angiogram results in the event of cardiac (heart-related) claims and any other test results pertinent to the claim event
6. Certified copy of life assured's ID document, no more than three (3) months old
7. Three (3) months bank statement of the life assured prior to incident

IMPORTANT CLAIM TIME LIMITS

1Life must be notified of an event that may result in a claim for a dread disease benefit within 3 (three) months of its occurrence. We may reject a claim if we do not receive notification within the prescribed periods.

- Initial claims documentation must reach us within 3 (three) months of the claim event
- Any additional documents required for processing the claim need must reach us within 3 (three) months of us requesting them.
- 1Life reserves the right to request further information that they deem necessary to complete the assessment of the claim
- Incomplete and/ or insufficient information may result in delays of the claim assessment

COMPLETED FORMS

The required documents plus this claim form, correctly completed and signed, must be submitted to 1Life using by email or fax.

- Email: claims@1life.co.za
- Fax: 086 010 5767

ENQUIRIES

For all claims related enquiries, please contact the claims department.

- Telephone: 0860 10 51 96
- Fax: 086 010 5767
- E-mail: claims@1life.co.za.

SECTION A: PARTICULARS OF THE INSURED

1. Policy Number: ____________ Title: ____________ Initials: ____________ Gender: ____________

First Names ______________________________ Surname ______________________________

ID/ Passport ______________________________ Language ____________

Postal Address ____

____ Code ____________

Physical Address ____

____ Code ____________

Telephone (Work) ______________________________ Fax (Work) ______________________________

Telephone (Home) ______________________________ Fax (Home) ______________________________

Cell ______________________________ E-mail ______________________________

Communication Preference ☐ Post ☐ Fax ☐ E-mail

Medical Aid ______________________________ Medical Aid Number ______________________________

SECTION B: DREAD DISEASE DETAILS

1. Based on the policy conditions and definitions of dread disease, for which dread disease condition that your policy covers are you claiming?

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2. Have you submitted a dread disease claim with 1Life or any other insurer before? Yes ☐ No ☐

3. If yes, please provide details and date of claim.

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4. On what date did the symptoms of the dread disease for which you are claiming start? Y Y Y Y M M D D

SECTION B: DREAD DISEASE DETAILS CONTINUED

1. On what date did you first consult a medical practitioner in connection with your current condition? Y Y Y Y M M D D

2. On what date was your dread disease condition first diagnosed? Y Y Y Y M M D D

3. State names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition. (Please provide hospital or clinic reference numbers)

(a) Doctor Surname ____________ Hospital/ Clinic ____________

Date Attended D D M M Y Y Y Y Reference No ____________

Address ____________

____________ Code ____________

(b) Doctor Surname ____________ Hospital/ Clinic ____________

Date Attended D D M M Y Y Y Y Reference No ____________

Address ____________

____________ Code ____________

(c) Doctor Surname ____________ Hospital/ Clinic ____________

Date Attended D D M M Y Y Y Y Reference No ____________

Address ____________

____________ Code ____________

4. Details of the doctor who is currently treating your condition.

Doctor Surname ____________ Initials ____________

Physical Address ____________

____________ Code ____________

Work Telephone ____________

5. Details of your family doctor.

Doctor Surname ____________ Initials ____________

Physical Address ____________

____________ Code ____________

Work Telephone ____________

SECTION C: BANK DETAILS OF THE INSURED

Name of Bank ______________________ Branch Name ______________________

Branch Code ______________________ Account No ______________________

Name of Account Holder ______________________ Account Type ______________________

______________________ ______________________

Signature of Account Holder Date

SECTION D: DECLARATION AND AUTHORISATION BY THE INSURED

Policy Number ID ______________________

Declaration

I, ______________________ (full names), declare that to the best of my knowledge all the information that I have given in this claim form is accurate and complete and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim.

I acknowledge that I fully understand the contents of this declaration.

Authorisation

I hereby authorise 1Life or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I further authorise 1Life or any of its representatives to release any information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed at ______________________ on this day ______________________ of 20______

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Signature of Claimant(s)