APPLICATION FOR PAYMENT OF A TERMINAL ILLNESS CLAIM

CLAIM REQUIREMENTS

1. Application for Payment of Terminal Illness 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

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.

COMPLETED FORMS

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

(086 010 5767) or email (claims@1life.co.za).

If there is more than one beneficiary, each beneficiary must complete a separate claim form.

1Life may require additional information in order to reach a decision on the claim.

IMPORTANT CLAIM TIME LIMITS

1Life must be notified of an event that may result in a Terminal Illness Benefit claim within 6 (six) 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

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 (W) _____ Fax (W) _____

Telephone (H) _____ Fax (H) _____

Cell _____ E-mail _____

2. Date of Diagnosis _____

3. Detailed description of medical illness. _____

_____

_____

_____

_____

_____

_____

_____

4. List any illnesses or incidents for which you have been hospitalised in the past

Date	Treating Doctor	Hospital	Diagnosis

SECTION A: PARTICULARS OF THE INSURED CONTINUED

5. Details of all doctors that attended to you in the past 5 years

a) Dr _____ Address _____

_____ Code _____

Telephone (Work) _____ Date Attended ____/____/____

b) Dr _____ Address _____

_____ Code _____

Telephone (Work) _____ Date Attended ____/____/____

c) Dr _____ Address _____

_____ Code _____

Telephone (Work) _____ Date Attended ____/____/____

6. Are you on medical aid? ☐ Yes ☐ No

7. Name of Medical Aid _____ 8. Medical Aid Number _____

9. Name of Hospital _____ 10. Hospital Ref Number _____

11. Company Where you work _____

Your Occupation _____

Manager or Supervisor's Name and Surname _____

Physical Address _____

_____ Code _____

Telephone (work) _____ Employee Clocking Number _____

Hours Worked Per Week _____ Start Date of Employment ____/____/____

SECTION B: PARTICULARS OF CLAIM BY CESSIONARY

Bank or Institution Name _____

Title _____ Initials _____ Gender _____ First Names _____

Surname _____ Amount Claimed _____

_____ _____

Signature of Claimant Date

SECTION C: BANK DETAILS OF CLAIMANT

Name of Bank _____ Branch Name _____

Branch Code _____ Account No _____

Name of Account Holder _____ Account Type _____

_____ _____

Signature of Account Holder Date

SECTION E: DECLARATION AND AUTHORISATION BY THE CLAIMANT

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_

_____

Signature of Claimant(s)