APPLICATION FOR PAYMENT OF AN EXPENSE PROTECTOR CLAIM

1Life
Changing Lives

WHAT IS A EXPENSE PROTECTOR CLAIM IN TERMS OF YOUR POLICY?

Occupation-Based Expense Protector pays out a monthly income if the life assured suffers a loss of income due to inability to perform the normal tasks required by his/her normal occupation due to injury or illness.

OR

Event-Based Expense Protector pays out a monthly income if the life assured becomes impaired due to accidental or natural causes and as a result suffers a loss of income.

WHAT DO WE REQUIRE FROM YOU TO ASSESS YOUR CLAIM?

1. Application for Payment of Expense Protector Claim form completed by claimant/ life assured (Attached)
2. Medical Attendant Report form completed by regular family doctor (GP) providing full medical history for the period before your policy commenced or was reinstated (Attached)
3. Copies of medical aid claim statements (if applicable)
4. Doctor's Statement completed by the life assured's treating specialist (Attached)
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. *Proof of income for the 6 month period before the claim incident
7. *Proof of loss of income for the period of the claim
8. If you are self-employed; company registration documents
9. Certified copy of your ID document, no more than three (3) months old
10. Your bank statement for three (3) months before the claim incident
11. If the claim event is due to accidental causes, a SAPS report and/ or accident report.

* **<u>Proof of income could include</u>**:

- RP5 documentation from employer
- SARS Income Tax Returns
- Payslip / Salary Advice from employer
- In the event of you being self-employed, confirmation from your company accountant/auditor to indicate your personal income
- Or any other confirmation of income as determined by the claims department

IMPORTANT CLAIM TIME LIMITS

1Life must be notified of an event that may result in a claim 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

WANT TO FOLLOW UP ON YOUR CLAIM OR HAVE ANY QUESTIONS?

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

- Telephone: 0860 10 51 96
- Fax: 0860 10 57 67
- E-mail: claims@1life.co.za

WHERE CAN YOU SEND YOUR COMPLETED FORMS?

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

- Fax: 0860 10 57 67
- Postal Address: PO Box 11250, Johannesburg, 2000
- E-mail: claims@1life.co.za

In the next set of questions, you need to give us information about you, our life assured.

SECTION A: PARTICULARS OF THE INSURED

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: ____________________

Communication Preference: ☐ Post ☐ Fax ☐ E-mail

Medical Aid: ____________________ Medical Aid Number: ____________________

Now, we need you to tell us about your condition.

SECTION B: TEMPORARY / PERMANENT DISABILITY DETAILS

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

- ☐ Cancer
- ☐ Cardiovascular (heart)
- ☐ Cerebrovascular (stroke)
- ☐ Major Organ Transplant or Chronic Organ failure
- ☐ Other Diseases of the Nervous System
- ☐ Gastrointestinal diseases
- ☐ Connective tissue diseases
- ☐ AIDS

2. What is your occupation? ____

3. Have you submitted a similar claim with 1Life or any other insurer before? YES ☐ NO ☐

4. If yes, please provide details and date of claim. ____

5. On what date did the symptoms for which you are claiming start? ____________________

Please remember to tell us about all the doctors, hospitals, clinics where you have received treatment for this condition.

We will also need to know about your medical history before the policy started, therefore it is important that you list your usual doctor or clinic name and details.

Please note that your **usual doctor** has to complete the attached **Certificate of Medical Attendant** form. We require information regarding any treatment and consultations before your policy started.

SECTION B: ILLNESS / INJURY DETAILS CONTINUED

1. On what date did you first consult a medical practitioner in connection with symptoms relating to your current condition? ______________________

2. On what date was your illness or condition first diagnosed ______________________

3. When was the last date that you were able to work? ______________________

4. When are you expected to return to work (part-time)? ______________________

5. When are you expected to return to work (full time) ______________________

6. What was your average monthly income for the 6 month period prior to the incident? R ______________________

7. What is your monthly income since the incident? R ______________________

8. 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 ______________________ Reference No ______________________

Address ______________________

______________________ Code __________

(b) Doctor Surname ______________________ Hospital/ Clinic ______________________

Date Attended ______________________ Reference No ______________________

Address ______________________

______________________ Code __________

(c) Doctor Surname ______________________ Hospital/ Clinic ______________________

Date Attended ______________________ Reference No ______________________

Address ______________________

______________________ Code __________

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

Doctor Surname ______________________ Initials __________

Physical Address ______________________

______________________ Code __________

Work Telephone ______________________

10. Details of your family doctor

Doctor Surname ______________________ Initials __________

Physical Address ______________________

______________________ Code __________

Work Telephone ______________________

You need to confirm your bank details for us. You also still need to submit a copy of a statement for 3 months before the date of the claim

SECTION C: BANK DETAILS OF THE INSUREDa

Name of Bank ______________________ Branch Name ______________________

Branch Code ______________________ Account No ______________________

Name of Account Holder ______________________ Account Type ______________________

______________________ ______________________

Signature of Account Holder Date

If we have to ask your doctors for information directly, or any other authorized person for information to assist with your claim, you will need to give us permission to do so.

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)