APPLICATION FOR PAYMENT OF AN EVENT-BASED DISABILITY CLAIM

CLAIM REQUIREMENTS:

1. Application for Payment of an Event-based Disability Claim form completed by claimant
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 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
8. If the claim event is due to accidental causes, a SAPS report and/ or accident report.

IMPORTANT CLAIM TIME LIMITS

1Life must be notified of an event that may result in a claim for an event-based disability 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 fax or email.

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

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 LIFE ASSURED

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 ☐

2. Date of Disability D D M M Y Y Y Y

3. Detailed Description of the Cause of Disability ________________________

4. Detailed Description of your Current Disability ________________________

5. Have you previously suffered from the same or similar illness? Yes ☐ No ☐

If "Yes", from what date? D D M M Y Y Y Y

6. On what date did the symptoms of the disability, for which you are claiming, start? D D M M Y Y Y Y

SECTION A: PARTICULARS OF THE LIFE ASSURED CONTINUED

7. Details of your Family Doctor

Dr ______________________________ Initials __________

Address ______________________________

______________________________ Code __________

Telephone (Work) ______________________________

8. Details of the Doctor/ Hospital/ Clinic that Treated you for this Problem

(a) Dr ______________ Initials __________ Hospital/ Clinic ______________

Date Attended D D M M Y Y Y Y Reference No ______________

Address ______________________________

______________________________ Code __________

Telephone (Work) ______________________________

(b) Dr ______________ Initials __________ Hospital/ Clinic ______________

Date Attended D D M M Y Y Y Y Reference No ______________

Address ______________________________

______________________________ Code __________

Telephone (Work) ______________________________

9. Medical Aid Details

Medical Aid ______________ Medical Aid Number ______________

SECTION B: ACCIDENT DETAILS (If an accident caused the disability)

1. Date of Accident D D M M Y Y Y Y Place ______________

2. Nature of Accident

____

____

____

SECTION B: ACCIDENT DETAILS CONTINUED

3. Details of Witnesses

   (a) Title ______ First Name ______ Surname ______

   Physical Address ______

   ______ Code ______

   Telephone ______

   (b) Title ______ First Name ______ Surname ______

   Physical Address ______

   ______ Code ______

   Telephone ______

4. Details of Police Station where Accident was Reported

   Police Station ______

   Physical Address ______

   ______ Code ______

   Telephone ______ Case Number ______

   Full Name, Rank and Police Number of Investigating Officer ______

5. Details of Any Legal Action Taken as a Result of the Accident ______

   ______

   ______

6. Details of the Doctor Consulted as a Result of the Accident

   Dr ______ Initials ______

   Address ______

   ______ Code ______

   Telephone (Work) ______

SECTION C: EMPLOYERS DETAILS

Name of Employer ______________________________

Physical Address ______________________________

______________________________ Code ____________

Telephone ____________________

Occupation ____________________ Employee Number ____________

Period of Employment From ____ / ____ / ____ To ____ / ____ / ____

SECTION D: BANK DETAILS OF THE LIFE ASSURED

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 LIFE ASSURED

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)