APPLICATION FOR PAYMENT OF AN OCCUPATION-BASED DISABILITY CLAIM

CLAIM REQUIREMENTS:

1. Application for Payment of Occupation Based Disability 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
8. If the claim event is due to accidental causes, a SAPS report and/ or accident report.
9. A Job description from the employer needs to be attached to this form

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

IMPORTANT CLAIM TIME LIMITS

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

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 ________ Email Address ________

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. ________

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4. Detailed description of your symptoms and how they affect your ability to perform your occupational duties. ________

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

If "YES"·, from what date? ________

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

7. From what date have you been totally disabled and unable to follow your normal? occupation? ________

SECTION A: PARTICULARS OF THE INSURED CONTINUED

8. Which duties from your normal occupation are you able and unable to do? ______________________

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9. What is your height? [ ][ ][ ] m What is your weight? [ ][ ][ ] kg

10. Details of your Family Doctor

Dr ______________________ Initials __________

Address ______________________

______________________ Code __________

Telephone (Work) ______________________

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

(a) Dr __________ Initials __________ Hospital/ Clinic __________

Date Attended __________ Reference No __________

Address ______________________

______________________ Code __________

Telephone (Work) ______________________

(b) Dr __________ Initials __________ Hospital/ Clinic __________

Date Attended __________ Reference No __________

Address ______________________

______________________ Code __________

Telephone (Work) ______________________

12. Medical Aid Details

Medical Aid __________ Medical Aid Number __________

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

1. Date of Accident ____________________ Place ____________________

2. Nature of Accident ____________________

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 Injury

Dr ____________________ Initials ________

Address ____________________

____________________ Code ________

Telephone (Work) ____________________

SECTION C: EMPLOYERS DETAILS

Period and Details of Employment:

(a) Name of Employer ____________________

Physical Address ____________________

____________________ Code ________

Telephone ____________________

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

Type of Work ____________________ Position Held ____________________

Percentage of Hours Spent On Travelling ________ % Administration ________ %

Supervision ________ % Manual Labour ________ %

(b) Name of Employer ____________________

Physical Address ____________________

____________________ Code ________

Telephone ____________________

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

Type of Work ____________________ Position Held ____________________

Percentage of Hours Spent On Travelling ________ % Administration ________ %

Supervision ________ % Manual Labour ________ %

(c) Name of Employer ____________________

Physical Address ____________________

____________________ Code ________

Telephone ____________________

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

Type of Work ____________________ Position Held ____________________

Percentage of Hours Spent On Travelling ________ % Administration ________ %

Supervision ________ % Manual Labour ________ %

SECTION D: BANK DETAILS OF THE INSURED

Name of Bank ______________________ Branch Name ______________________

Branch Code ______________________ Account No ______________________

Name of Account Holder ______________________ Account Type ______________________

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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_

____
Signature of Claimant(s)