



# TERMINAL ILLNESS CLAIM FORM

Policy number:

## GUIDELINES ON SUBMISSION OF A CLAIM:

- Please print in block letters using black or blue ink.
- Section 1 – Must be completed and signed by the claimant/Contracting Party where appropriate.
- Section 2 – Must be completed and signed by the claimant's attending doctor.

**IMPORTANT: PLEASE CONTINUE PAYING YOUR MONTHLY CONTRIBUTIONS TO AVOID BENEFITS CEASING.**

## 1. TO BE COMPLETED BY THE CLAIMANT

### CONTRACTING PARTY DETAILS

Title      Mr:       Ms:       Mrs:       Other:       Initials:

Surname/  
Name of institution:

First names/  
Contact person:

Previous surname  
(if applicable):

ID number/Institution  
registration number:

Passport number:  (where no South African ID number is available)

Country of issue  
of passport:

Date of birth:  Y  Y  Y  Y  M  M  D  D      Age at next birthday:        Gender: Male       Female:

Income tax number:       Are you a South African resident? Yes       No

Residential address/  
Physical address  
of institution:

Postal address:

Telephone:      (W):       (H):   
Fax:       Cell:

Email address:

Marital status:      Single       Married       Divorced       Widowed       Correspondence Language: English       Afrikaans

The Financial Services Charter requires life insurance companies to report on the racial spread of their client bases. Please assist us to fulfil our obligations under the Charter by indicating to us the race group to which you feel you belong. This information will be used only for determining (and reporting on) the racial spread of our client base.

Race:      Black       Indian       Coloured       White

## CONTRACTING PARTY DETAILS

Name of bank:

Branch name:  Branch code:

Account holder's name:

Account number:

Account holder relationship: Own account  Joint account  3rd Party account

## DECLARATION

### PROTECTION OF PERSONAL INFORMATION (PPI) NOTICE

The Old Mutual Group would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that are suitable to your financial needs. If you do not want to receive such information or financial services, **SMS your ID number to 45600.**

We may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification
- Claims checks (ASISA Life and Claims Register)
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- To comply with legal and regulatory requirements
- Verifying your identity
- Sharing with service providers we engage to process information on your behalf.

You may access the information that we hold about you and ask us to correct any errors or delete the information we have about you. To view our full privacy notice and to exercise preferences, visit our website on [www.oldmutual.co.za](http://www.oldmutual.co.za).

I irrevocably authorise:

- Old Mutual to obtain information, from any person, which is needed to assess claims;
- the concerned person (in a) to give Old Mutual the required information;
- Old Mutual to share obtained information, which includes information contained in any pertinent document or contract, with other insurers and the Life Offices' Association of South Africa (LOA), to assess risks or claims;
- the LOA to give any such information received from Old Mutual to other insurers to assess risk or claims. Any information may, under this authorisation, be obtained or given at any time, even after my death, and in such detail, or in such abbreviated or coded form, as Old Mutual or the LOA may from time to time decide.

I understand that my right to privacy is curtailed to the extent permitted by me in this authorisation. This information may be used by Old Mutual to determine the validity of this claim. By signing below, I certify that I agree to the prepayment of the death benefits under the abovementioned plan(s). I understand that if my request for this prepayment is approved, the full cover amount of the death benefit(s) will be payable as full and final settlement of these benefit(s). I understand that the benefit(s) will cease after this payment.

Signature of claimant:

Date:

## 2. TO BE COMPLETED BY THE ATTENDING DOCTOR

A terminal illness is defined as a medical condition that, with reasonable medical certainty in the opinion of Old Mutual's Chief Medical Officer, will result in the death of the life assured within twelve months of the date medical evidence to that effect is provided.

Date of first visit:  Y  Y  Y  Y  M  M  D  D Date of last visit:  Y  Y  Y  Y  M  M  D  D

Diagnosis:

### A. Present condition

Please provide us with sufficient detail of the claimant's present condition to support that a reasonable assessment of the life expectancy of the claimant is less than twelve months.

  
  
  

### B. General

1. Please indicate the terminal illness from which the claimant is suffering, with the appropriate international staging of the disease, where applicable. To support the claim, please provide us with copies of all tests, investigations and reports in your possession.

  
  

2. If the claimant is suffering from Carcinoma, please provide us with a copy of the histology report and a detailed staging of the disease to enable Old Mutual to arrive at the appropriate decision.

  

3. If the claimant is HIV positive, please advise the current stage.

  

I certify that I have personally attended the patient and that all the foregoing statements are correct to the best of my knowledge.

Initials:  Surname:

Qualifications:

Address:

Practice number:

Name of hospital:

Address of hospital:

Telephone no:  Fax no:

Signed at:  the  day of  20

Signature of medical attendant:

Date:  Y  Y  Y  Y  M  M  D  D