# CRITICAL ILLNESS CLAIM

To whom it may concern,

Please find below the critical illness claim form to be completed and signed. This form as well as the documents listed below, must be submitted to Different Life via email or in person.

If in person, please deliver to:
Building A, Bryanston Corner, 18 Ealing Crescent, Bryanston, Johannesburg 2021

**REQUIRED DOCUMENTS**

**To initiate the claim process:**

The original or certified copies, signed by a commissioner of oaths, of the following:

1. The insured's ID document.
2. The medical certificate completed by the doctor who is currently treating or who has treated the insured

**To effect payment on the claim (if the claim is assessed as valid):**

The original or certified copies, signed by a commissioner of oaths, of the following:

1. Three (3) month's bank statements of the claimant.

## PARTICULARS OF THE INSURED

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Policy Schedule Number | | | | | | | | | | | | | | |
| First Names | | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | Title | Miss Mrs Mr Dr Prof | |
| Initials | | Gender | Female Male | | | | | | | | | Language | | |
| ID / Passport / Card Driving Licence Official Number | | | | | | | | | | | | | | |
| Postal Address | | | | | | | | | | | | | | |
| | | | | | | | | | | | | Postal Code | | |
| Physical Address | | | | | | | | | | | | | | |
| | | | | | | | | | | | | Postal Code | | |

| | |
|---|---|
| Telephone (w) | Fax (w) |
| Telephone (h) | Fax (h) |
| Cellphone | Communication Preference  Post  Fax  e-mail |
| E-mail address | |
| Medical Aid | Medical Aid Number |

## CRITICAL ILLNESS DETAILS

Based on the policy conditions and definitions of critical illness, for which illness are you claiming?

| | | |
|---|---|---|
| Have you submitted a critical illness claim before? | Yes | No |

If yes, please provide details and date of claim

| | Y Y Y Y M M D D |
|---|---|
| On what date did the symptoms of the critical illness for which you are claiming for start? | |
| On what date did you first consult a medical practitioner in connection with your current condition? | |
| On what date was your critical illness first diagnosed? | |

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 | Address |
| | |
| Hospital / Clinic | Ref. No. |

| | Y Y Y Y M M D D |
|---|---|
| Date attended | |

| B. Doctor | Address |
|---|---|
| | |
| Hospital / Clinic | Ref. No. |

| | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|
| Date attended | | | | | | | | |

| C. Doctor | Address |
|---|---|
| | |
| Hospital / Clinic | Ref. No. |

| | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|
| Date attended | | | | | | | | |

## DETAILS OF THE DOCTOR WHO IS CURRENTLY TREATING YOUR CONDITION

| Surname | Initials |
|---|---|
| Physical Address | |
| | Postal Code |
| Telephone (w) | |

## BANK DETAILS OF THE INSURED

| Name of Bank | Branch Name |
|---|---|
| Account Number | Branch Code |
| Name of Account Holder | Account Type |

Signature of Account Holder _____

| | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | |

## DECLARATION AND AUTHORISATION BY THE INSURED

Policy Schedule Number

**Declaration**

I 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 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 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 _____

Signature of Claimant _____

| | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | |