



GREENLIGHT

RSA DEATH CLAIM FORM
CERTIFICATE OF MEDICAL ATTENDANT

Contract number

Grid for contract number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Grid for intermediary code

Please print in block letters using black or blue ink.

This form is issued without admission of liability and must be completed and signed by the medical attendant.

Please email the completed form to claims@oldmutual.com

Intermediary/Admin support:

Name of contact person

Email address and telephone number of contact person

IMPORTANT NOTES

Please note that Old Mutual can only consider a claim on receipt of the following documents, marked with the contract number and intermediary code where applicable:

- 1. A certified copy of the life covered's ID and/or contracting party's ID if different.
2. Please ensure that the copies of specialist reports and test results are attached to this claim form.
3. The fee for this report (including supporting documentation) will be paid by Old Mutual in accordance with the tariff laid down by the S.A. Medical and Dental Council (code A1401).

There may be further requirements before the claim can be considered.

SECTION 1 DETAILS OF DECEASED

Surname

Full names

Date of birth

Date of death

Please complete this form with regard to the deceased's medical history prior to

SECTION 2 MEDICAL HISTORY

1. For which period was the deceased a patient of the practice?

From To

2. Patient file number

3. Was the deceased a member of a medical aid? YES NO

If "YES", please provide full details.

Table with 2 columns: Label (Name of medical aid, Membership number, Contact details) and Value

4. Nature of any complaints for which the deceased consulted the practice.

Date	Symptoms	Diagnosis (BP reading, lab, test results)	Treatment

5. Was the deceased ever hospitalised or admitted to any institution?

YES  NO

If "YES", please provide reason.

Hospital/Institution	Date

6. Please furnish us with details of any other doctors/specialists/hospital or institution consulted by the deceased.

Name	Reason	Date

\* Please provide copies of all reports.

7. Did the deceased use alcohol or drugs in excess?

YES  NO

If "YES", please provide full details.

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8. a) Is there any reason to believe that the life covered's death is in any way due to or arose directly or indirectly, entirely or partially from an AIDS or HIV infection?

YES  NO

If "YES", please provide full details.


b) Has the life covered ever been tested for HIV antibodies?

YES  NO

If "YES", please provide full details.

Date	By whom?	Results

9. If known, please provide.

Date of death  Age at death  Place of death

10. a) Immediate cause of death (if known)

b) Date of commencement of illness relating to cause of death

c) Date when deceased first became aware of the illness or any symptoms

11. Was an inquest or post mortem held?

YES  NO

If "YES", where was it held?

Findings


12. Diseases or conditions which preceded or co-existed with the immediate cause of death.

Disease/condition	Date commenced	Date consulted

13. State in full if any of the following influenced or contributed to the cause of death:

YES  NO

Previous illness or injury	
Family history	
Habits	

14. Please provide any other information you may deem relevant.


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### SECTION 3 DECLARATION BY MEDICAL ATTENDANT

I, the undersigned, a registered medical practitioner, certify to the above information in respect of the life covered and understand that the fee for this report (including supporting documentation) will be paid by Old Mutual in accordance with the tariff laid down by the S.A. Medical and Dental Council.

Surname

Full names

Practice number

Qualification

Contact number

Address  Postal code

Please indicated amount based on the tariff of fees R

I certify that I have personally attended to the patient and that all the foregoing statements are correct to the best of my knowledge. I confirm that I will adhere to all the applicable Data Protection legislation.

Signed at (place)  on (date)

Signature of medical attendant



<b>Old Mutual Claim Contact Details:</b>			
Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

Contract number



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