



GREENLIGHT

RSA SEVERE ILLNESS BENEFIT CLAIM FORM

STATEMENT BY CONTRACTING PARTY

Contract number

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

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 contracting party and life covered (if different to the contracting party).

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

The premium must continue to be paid to avoid plan/benefits ceasing.

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:

- Severe Illness Benefit Claim Form Statement by claimant
- Severe Illness Benefit Claim Form Statement by medical specialist and supporting evidence as specified
- A certified copy of the life covered's ID and/or contracting party's ID if different
- Proof of bank details, e.g. cancelled cheque, bank statement not older than 3 months, confirmation on a bank letterhead

There may be further requirements before the claim can be considered. These depend on the benefit concerned and the cause of illness.

SECTION 1 DETAILS OF CONTRACTING PARTY

Is the life covered the same person? YES NO

Title: Mr Ms Mrs Other Initials

Surname/ Name of institution

Full names/ Contact person

Previous surname (if applicable)

ID/Passport/Institution registration number Date of birth

Income tax number

Residential address/ Physical address of institution Postal code

Postal address Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

SECTION 2 DETAILS OF LIFE COVERED (IF DIFFERENT TO CONTRACTING PARTY)

Title: Mr Ms Mrs Other Initials

Surname

Full names

ID/Passport number Date of birth

Income tax number

Residential address Postal code

Postal address Postal code

Country of address

Contact number (Work) Code No.
 (Home) Code No.
 Cellphone number

Email address

SECTION 3 DETAILS OF BENEFICIARY

Title: Mr Ms Mrs Other Initials

Surname/
Name of institution

Full names/
Contact person

Previous surname
(if applicable)

ID/Passport/Institution
registration number Date of birth

Income tax number

Residential address/
Physical address of
institution Postal code

Postal address Postal code

Country of address

Contact number (Work) Code No.
 (Home) Code No.
 Cellphone number

Email address

SECTION 4 BANKING DETAILS OF LIFE COVERED (OR BENEFICIARY, IF DIFFERENT)

Name of bank

Branch name Branch code

Account holder
name

Account number ID number of
account holder

Account holder relationship: Own account Joint account
 Type of account: Cheque Savings Transmission

Contract number

SECTION 5 MEDICAL HISTORY

On what date did you first consult a medical practitioner in connection with your current impairment?

D	D	M	M	Y	Y	Y	Y
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Please provide the name(s) and address(es) of all medical practitioners and hospitals involved, and referral date(s).

Name (medical practitioner/hospital)	Address	Medical condition/procedure	Duration

Have you previously received any medical, chiropractic or psychological attention, treatment or medication? (Excluding colds, influenza and general children's ailments)

YES NO

If "Yes", please state the nature of the illness and give names and addresses of the doctors and hospitals consulted, including the dates of occurrence.

Name (medical practitioner/hospital)	Address	Medical condition/procedure	Duration

Are you a member of a medical aid?

YES NO

Name of medical aid	
Member number	
Name of main member	

SECTION 6 PARTICULARS OF ILLNESS

What illness is being claimed for? Please tick the relevant block.

(You are advised to refer to your contract, as all the conditions listed below may not be covered by your specific contract.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Accidental brain injury | <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Early cervical cancer |
| <input type="checkbox"/> Accidental HIV for medical, dental or nurse practitioners | <input type="checkbox"/> Cancer | <input type="checkbox"/> Early oesophageal cancer |
| <input type="checkbox"/> Accidental HIV via a blood transfusion | <input type="checkbox"/> Cancer benefit enhancer | <input type="checkbox"/> Early ovarian cancer |
| <input type="checkbox"/> Accidental HIV via a road traffic accident | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Early prostate cancer |
| <input type="checkbox"/> Accidental HIV via an organ transplant | <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Early testicular cancer |
| <input type="checkbox"/> Accidental HIV via violent crime, rape or indecent assault | <input type="checkbox"/> Cavernous sinus thrombosis | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Acquired mental retardation | <input type="checkbox"/> Cerebral aneurysm | <input type="checkbox"/> Endocrine disorders |
| <input type="checkbox"/> Activities of daily living | <input type="checkbox"/> Cerebral arteriovenous malformation | <input type="checkbox"/> Eye stroke |
| <input type="checkbox"/> Acute renal disease | <input type="checkbox"/> Cerebral malaria | <input type="checkbox"/> Gastrointestinal stromal tumour |
| <input type="checkbox"/> Advanced rheumatoid arthritis | <input type="checkbox"/> Chronic blood disorders | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Advanced skin cancer: Basal cell carcinoma | <input type="checkbox"/> Chronic kidney failure | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Advanced skin cancer: Squamous cell carcinoma | <input type="checkbox"/> Chronic liver failure | <input type="checkbox"/> Heart transplant |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chronic pancreatitis | <input type="checkbox"/> Heart valve replacement or repair |
| <input type="checkbox"/> Amputation of limb | <input type="checkbox"/> Chronic respiratory failure | <input type="checkbox"/> Hematopoietic stem cell (bone marrow) transplant |
| <input type="checkbox"/> Amputation of the penis | <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Hemiparesis or cranial nerve deficit |
| <input type="checkbox"/> Angioplasty and/or stenting | <input type="checkbox"/> Coma | <input type="checkbox"/> Inflammatory bowel disease |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Juvenile onset recurrent respiratory papillomatosis |
| <input type="checkbox"/> Aortic surgery | <input type="checkbox"/> Coronary artery bypass graft | <input type="checkbox"/> Kidney transplant |
| <input type="checkbox"/> Bacterial meningitis | <input type="checkbox"/> Crohn's disease with specified surgery | <input type="checkbox"/> Less extensive burns |
| <input type="checkbox"/> Benign brain tumour | <input type="checkbox"/> Cushing's disease | <input type="checkbox"/> Life threatening arrhythmia |
| <input type="checkbox"/> Bilateral angioplasty and/or stenting | <input type="checkbox"/> Dementia (including alzheimers disease) | <input type="checkbox"/> LifeQuality |
| <input type="checkbox"/> Bilateral carotid artery surgery | <input type="checkbox"/> Early bladder cancer | <input type="checkbox"/> Lifestyle enhancer |
| <input type="checkbox"/> Bone marrow failure (including severe aplastic anaemia) | <input type="checkbox"/> Early breast cancer | <input type="checkbox"/> Liver transplant |

Contract number

- | | | |
|---|---|---|
| <input type="checkbox"/> Lobectomy | <input type="checkbox"/> Pancreas transplant | <input type="checkbox"/> Pulmonary artery surgery |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Pancreatectomy | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Loss of sight | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Recurrent pulmonary emboli |
| <input type="checkbox"/> Loss of speech | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Retinitis pigmentosa |
| <input type="checkbox"/> Lung transplant | <input type="checkbox"/> Parkinson's plus syndrome | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Major artery aneurysm | <input type="checkbox"/> Partial Mastectomy | <input type="checkbox"/> Spinal cord tumour |
| <input type="checkbox"/> Major burns | <input type="checkbox"/> Pathway ablation | <input type="checkbox"/> Status epilepticus |
| <input type="checkbox"/> Minor heart surgery | <input type="checkbox"/> Pericardiectomy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Minor stroke | <input type="checkbox"/> Peripheral arterial disease | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Motor neurone disease | <input type="checkbox"/> Permanent ileostomy or colostomy | <input type="checkbox"/> Terminal illness |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Pneumonectomy | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Polymyositis | <input type="checkbox"/> Type I diabetes |
| <input type="checkbox"/> Myasthenia gravis | <input type="checkbox"/> Pseudomyxoma peritonei | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Neuroendocrine tumours | <input type="checkbox"/> Psychiatric disorders | <input type="checkbox"/> Wegener's granulomatosis |
| <input type="checkbox"/> Pacemaker or defibrillator insertion | <input type="checkbox"/> Pulmonary arterial hypertension | |

When was the condition diagnosed?

* The life covered should only claim under the LifeQuality or Activities of daily living event if he/she does not qualify for the payment for any other illness.

SECTION 7 DECLARATION BY LIFE COVERED AND CONTRACTING PARTY

PROTECTION OF PERSONAL INFORMATION ACT (POPIA) 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 may be suitable to meet your financial needs. Please SMS your ID number to **30994** if you would prefer not to receive such information and/or financial services.

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 of personal information
- Claims checks (ASISA Life and Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect your personal information.

You may access your personal information that we hold and may also request us to correct any errors or to delete this information. In certain cases you have the right to object to the processing of your personal information.

You also have the right to complain to the Information Regulator, whose contact details are:

Website www.justice.gov.za/infocreg/index.html
 Contact Number 012 406 4818
 Fax 086 500 3351
 Email infocreg@justice.gov.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za

1. I hereby declare that the details provided in this form are true, correct and complete.
2. I declare that the medical condition of the life covered is not directly or indirectly caused by any of the medical conditions excluded in the terms and conditions of the contract.

Signed at (place) on (date)

Signature of contracting party

Signature of life covered (if different to the contracting party)

Old Mutual Claim Contact Details:

Email claims@oldmutual.com
 Telephone number RSA: 0860 10 22 74
 International: +27 21 503 1802

Fax number 0860 60 45 02
 Address PO Box 202, Mutualpark 7451, South Africa.



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Old Mutual is a Licensed Financial Services Provider