



GREENLIGHT

# RSA CHILD IMPAIRMENT AND CONGENITAL BIRTH DEFECTS 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 a witness.

Please email the completed form to [claims@oldmutual.com](mailto: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:

- Child Impairment and Congenital Birth Defects Benefit Claim form Statement by contracting party
- Child Impairment and Congenital Birth Defects Benefit Claim form Statement by medical specialist
- A certified copy of the life covered's ID
- Proof of birth of child, i.e. certified copy of unabridged birth certificate or certified copy of Confirmation of Birth form issued by hospital at the time of birth
- 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.

### 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

Previous surname (if applicable)

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 (IF DIFFERENT TO CONTRACTING PARTY)**

Title: Mr  Ms  Mrs  Other  Initials

Surname

Full names

Previous surname (if applicable)

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 4 BANKING DETAILS OF CONTRACTING PARTY (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 DETAILS OF CHILD

Surname

Full names

ID number  Date of birth

Is the child an adopted child of the life covered? YES  NO

Name of father

ID number of father

Name of mother

ID number of mother

## SECTION 6 MEDICAL HISTORY

When was your child's current condition/birth defect diagnosed (this includes diagnoses made in utero)?

Who initially diagnosed your child's condition/birth defect?

Doctor's name	<input type="text"/>
Contact number	<input type="text"/>

Please provide the name(s) and address(es) of all medical practitioners and hospitals involved in your child's medical care, and referral dates.

Name	Address	Date	Duration
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## SECTION 7 DETAILS OF THE CHILD'S IMPAIRMENT/BIRTH DEFECT

What impairment/birth defect is being claimed for? Please tick the relevant block.

- |  |  |
|--|--|
| <input type="checkbox"/> Accidental Brain Damage                             | <input type="checkbox"/> Haemophilia   |
| <input type="checkbox"/> Anal Atresia  | <input type="checkbox"/> Hypospadias   |
| <input type="checkbox"/> Biliary Atresia                                     | <input type="checkbox"/> Inborn Metabolic Disorders                          |
| <input type="checkbox"/> Cerebral Palsy                                      | <input type="checkbox"/> Loss of Hearing                                     |
| <input type="checkbox"/> Cleft Palate  | <input type="checkbox"/> Loss of Sight                                       |
| <input type="checkbox"/> Clubbed Feet  | <input type="checkbox"/> Loss of Speech                                      |
| <input type="checkbox"/> Congenital Deafness                                 | <input type="checkbox"/> Major Burns   |
| <input type="checkbox"/> Congenital Heart Disease                            | <input type="checkbox"/> Neuro-developmental Disorders                       |
| <input type="checkbox"/> Congenital Hip Dislocation                          | <input type="checkbox"/> Permanent confinement to bed or wheelchair          |
| <input type="checkbox"/> Cystic Fibrosis                                     | <input type="checkbox"/> Spina Bifida  |
| <input type="checkbox"/> Down's Syndrome                                     | <input type="checkbox"/> Terminal Illness                                    |
| <input type="checkbox"/> Duchenne Syndrome and Congenital Myotonic Dystrophy | <input type="checkbox"/> Tracheo-oesophageal Fistula and Oesophageal Atresia |

Contract number

## SECTION 8 DECLARATION BY THE 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/infoereg/index.html](http://www.justice.gov.za/infoereg/index.html)  
Contact Number 012 406 4818  
Fax 086 500 3351  
Email [infoereg@justice.gov.za](mailto:infoereg@justice.gov.za)

To view our full privacy notice and to exercise your preferences, please visit our website on [www.oldmutual.co.za](http://www.oldmutual.co.za)

I hereby declare that the life covered is the person assured under the abovementioned benefit(s), that all the particulars given are true and complete, and that the child's condition was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in the exclusions of the terms and conditions attached to the benefit(s) in question.

Signed at (place)  on (date)

Signature of contracting party

Signature of witness

#### Old Mutual Claim Contact Details:

Email [claims@oldmutual.com](mailto: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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