OLDMUTUAL

GREENLIGHT

RSA DISABILITY 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

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:

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

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

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 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

SECTION 4 INFORMATION REGARDING YOUR MEDICAL CONDITION

4.1 Describe in your own words, the cause of your medical condition.

4.2 If your medical condition was due to an accident, please state:

(a) Describe in your own words, the cause of your medical condition.

(b) Address of police station (if any) to which the accident was reported and case number (if applicable).

4.3 Which parts of your body are affected by the medical condition?

4.4 What is the impact of the medical condition on the affected body parts?

Contract number

4.5 Describe the impact of the medical condition on your ability to do the following:

(a) thinking clearly	
(b) concentrating	
(c) making decisions	
(d) interacting with others	
(e) walking	
(f) sitting in a chair	
(g) writing and typing	
(h) reading	
(i) operating machinery	
(j) carrying and lifting	
(k) driving	
(l) feeding	
(m) toileting	

4.6 Are there any other daily activities that are affected by your medical condition? YES ☐ NO ☐

Please describe in full.

SECTION 5 DETAILS OF TREATMENT

5.1 On what date did you first consult a medical practitioner in connection with your current medical condition? D D M M Y Y Y Y

Please provide name(s) and address(es) of all medical practitioner(s) and hospital(s) involved, and referral date(s)

Name	Address	Medical condition	Date	Duration

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

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	Address	Medical condition	Date	Duration

5.3 Are you a member of a medical aid? YES ☐ NO ☐

Name of medical aid	
Member number	
Name of main member	

5.4 Do you feel your condition is improving because of the treatment? YES ☐ NO ☐

If "YES", please describe in full.

5.5 Has any medical specialist given you advice or prescribed treatment for your medical condition that you have not adhered to? YES ☐ NO ☐

If "YES", please provide full.

Contract number ☐☐☐☐☐☐☐☐☐☐

SECTION 6 DETAILS OF OCCUPATION

6.1 What was your occupation when the medical condition commenced?

6.2 Please give a complete description of the duties and daily activities of your occupation or enclose a copy of your job description.

(a) Administrative ___ %

(b) Manual ___ %

(c) Supervisory ___ %

(d) Travelling ___ %

6.3 Please describe how your medical condition has affected your ability to perform each of the duties and daily activities listed in 6.2 above.

6.4 When do you expect to be able to resume your current occupation?

☐ Full capacity D D M M Y Y Y Y

☐ Partial capacity D D M M Y Y Y Y

6.5 When last were you able to work (last date of work)? D D M M Y Y Y Y

6.6 For each occupational duty that you are no longer able to perform, please indicate when this inability began?

Occupational duty

	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

6.7 Were you engaged in any other occupation (permanent or part-time) immediately after your medical condition commenced? YES ☐ NO ☐

If "YES", please give details including dates below.

Name of occupation

	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y

SECTION 7 EDUCATION, TRAINING AND WORK EXPERIENCE

7.1 Please state details (with dates) of all occupations followed by you during the past 10 years.

Occupational duty

	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

Contract number

7.2 What school, academic, professional or trade qualifications do you possess?

7.3 What alternative occupations do you consider yourself able to perform, with regard to your education, training or experience?

7.4 When do you expect to be able to begin the above alternative occupations?

On a full-time basis? D D M M Y Y Y Y

On a part-time basis? D D M M Y Y Y Y

7.5 Give the name and address of your most recent employer.

7.6 Have you been discharged from your present occupation? YES NO

If "YES", please provide full details.

7.7 If self-employed, is your business being conducted on your behalf while you are unable to work? YES NO

If "YES", please provide full details.

If "No", which of the following duties do you still perform?

(a) Administrative % (b) Manual % (c) Supervisory % (d) Travelling: car/truck %

7.8 Are you currently receiving any form of disability compensation? YES NO

If "YES", please provide details (amount, type of benefit, recurring/lump sum, company, reference number).

7.9 Is any other disability claim on your life pending or contemplated? YES NO

If "YES", please provide details (amount, type of benefit, recurring/lump sum, company, reference number).

SECTION 8 INCOME INFORMATION

8.1 Please provide full details of your earnings in the 12 months prior to commencement of your medical condition. Also provide details of any fluctuating income (commission, bonuses, etc.) received in the three years prior to commencement of your medical condition.

8.2 Please provide details of any income or benefit you are receiving from your pre-disability employer. Indicate for how long you expect this income or benefit to continue.

8.3 Have you been engaged in any occupation (full or part-time) since your medical condition arose? YES NO

If "YES", please provide full details of the occupation as well as full details of earnings in this occupation.

8.4 Do your employer provide paid sick leave? YES NO

If "YES", please provide full details (including the number of leave days available).

Additional requirements may be requested at Old Mutual's discretion, e.g. salary slips, tax returns.

Contract number

SECTION 9 ADDITIONAL INFORMATION

9.1 Have you travelled or resided outside the RSA in the past 12 months? YES ☐ NO ☐

If "YES", please provide full details including dates.

SECTION 10 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/inforeg/index.html
Contact Number	012 406 4818
Fax	086 500 3351
Email	inforeg@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 that led to the disablement 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) D D M M Y Y Y Y

Signature of contracting party

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

Old Mutual Claim Contact Details:

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.

OLDMUTUAL

Contract number ☐☐☐☐☐☐☐☐☐☐

Old Mutual is a Licensed Financial Services Provider