CRITICAL ILLNESS BENEFIT CLAIM FORM – CLAIMANT & EMPLOYER

Please return to: Hollard Group Risk, Florence House, 22 Oxford Road, Parktown 2193 or PO Box 87419, Houghton
Tel: (011) 351 5000. Fax: (011) 351 3079. Email: hgrdisability@hollard.co.za

SECTION A: HOW TO CLAIM

Two forms are required for the submission of a critical illness claim.

1. CRITICAL ILLNESS CLAIM FORM – CLAIMANT & EMPLOYER (to be completed by the claimant and the employer)
2. CRITICAL ILLNESS CLAIM FORM – MEDICAL ATTENDANT'S REPORT (to be completed by the claimant/employer and the medical attendant)

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family. In the event that the claimant is incapacitated, the sections to be completed by the claimant must be completed by the claimant's caretaker and/or the employer. We require an affidavit confirming the claimant's inability to complete and sign the claimant's personal declaration.

It is essential that both forms are fully completed to prevent any unnecessary delays due to missing or incomplete information. It is the employer's responsibility to compile all the documents required and to submit them to Hollard Life. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in nine sections:

- Section A: How to claim (informative section)

To be completed by either claimant or employer or both:

- Section B: Policy details
- Section C: Employer's details
- Section D: Claimant's personal details

To be completed by claimant:

- Section E: Claimant's report on diagnosis of critical illness
- Section F: Banking details
- Section G: Declaration

To be completed by employer:

- Section H: Employer's report
- Section I: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the claimant's identity document
- a copy of the claimant's payslip for the last completed month of employment
- proof of banking details (cancelled cheque or bank statement)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information. If necessary, we may need to share either your personal or medical information, or both, with third parties. These third parties are other insurance and or reinsurance companies, or service providers that may assist us in assessing and managing the risk, or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us.

By providing the required personal and medical information, and signing this declaration of health, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties.

SECTION B: POLICY DETAILS (to be completed by employer or claimant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS (to be completed by employer or claimant)

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

Email address:

SECTION D: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant)

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cell phone number:

Email address:

Occupation:

SECTION E: CLAIMANT'S REPORT ON DIAGNOSIS OF CRITICAL ILLNESS (to be completed by claimant)

1. What critical illness have you been diagnosed with?

2. What is the date of the diagnosis? D D M M Y Y Y Y

3. Who is the medical attendant who made the diagnosis?

Telephone number

4. Have you previously received any benefits from any other insurance company? Y N
If "Yes", please provide details:

SECTION F: BANKING DETAILS (to be completed by claimant)

Payment will be made to the claimant only.

Name of account holder:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

SECTION G: DECLARATION (to be signed and dated by claimant)

I, hereby declare that I am the person insured under the policy mentioned above.

The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. I agree that all the written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that Hollard Life reserves the right to proceed with the appropriate action against the claimant.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the consideration of my claim I irrevocably authorise Hollard Life:

a) to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Life deems necessary, and
b) to share with other insurers that information and any information contained in this claim form or in any related document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Hollard Life or by the operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information Hollard Life may require relating to my medical history, my injury, my employment history and/or any other information which may

be necessary for Hollard Life's consideration of the claim. I also agree that any information provided by me may be verified against other sources or data bases.

Signed at _____ on this _____ day of _____ 20 _____

Claimant's name

Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name

Signature

OR

Employer's name

Signature

SECTION H: EMPLOYER'S REPORT (to be completed by employer)

1. When did the claimant join the company? D D M M Y Y Y Y

2. When did the claimant join the critical illness benefit scheme? D D M M Y Y Y Y

3. Month last risk premium was paid for? M M Y Y Y Y

4. What was the claimant's salary as at the date of the diagnosis of the critical illness? R

5. What was the effective date of this salary? D D M M Y Y Y Y

SECTION I: DECLARATION (to be signed by employer)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life.

Signed at _____ on this _____ day of _____ 20 _____

Name of authorised signatory

Designation

Signature
For and on behalf of the policyholder

Company Stamp

CRITICAL ILLNESS BENEFIT CLAIM FORM – MEDICAL ATTENDANT'S REPORT

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SECTION A: HOW TO CLAIM

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family.

The medical attendant must complete this form to confirm the diagnosis of the critical illness.

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form may be submitted to Hollard Life by the employer, claimant or the medical attendant.

This form is structured in six sections:

- Section A: How to claim (informative section)
- Section B: Policy details (to be completed by employer or claimant)
- Section C: Claimant's personal details (to be completed by employer or claimant)
- Section D: Medical attendant's details (to be completed by the medical attendant)
- Section E: Medical information (to be completed by the medical attendant)
- Section F: Declaration (to be signed by the medical attendant)

This fully completed form should be accompanied by the following supporting documentation:

- copies of any reports (e.g. EEG, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results etc.)
- copies of any additional information to substantiate the claim

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information. If necessary, we may need to share either your personal or medical information, or both, with third parties. These third parties are other insurance and or reinsurance companies, or service providers that may assist us in assessing and managing the risk, or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us.

By providing the required personal and medical information, and signing this declaration of health, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties.

SECTION B: POLICY DETAILS (to be completed by claimant, before form is completed by medical attendant)

Employer: ☐

Policyholder: ☐

Policy number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership / Employee number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SECTION C: CLAIMANT'S PERSONAL DETAILS (to be completed by claimant, before form is completed by medical attendant)

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cell phone number:

Email address:

SECTION D: MEDICAL ATTENDANT'S DETAILS (to be completed by medical attendant)

Title: First names:

Surname:

Qualifications:

Practice Number:

Physical address:

Code:

Postal address:

Code:

Telephone number:

Fax number:

Email address:

SECTION E: MEDICAL INFORMATION (to be completed by medical attendant)

1. What is the diagnosis of the claimant's condition?

2. Does the claimant have a past history of this condition?
If "Yes", please provide details.

3. Date of diagnosis of the claimant's condition: D D M M Y Y Y Y

4. Please refer to Annexure One for the full definitions of the following critical illness conditions. Please advise which of the following conditions accurately describes the claimant's condition by ticking the applicable critical illness.

- Heart attack – Level A: Heart attack with severe permanent impairment in function
- Heart attack – Level B: Heart attack with mild permanent impairment in function
- Heart attack – Level C: Heart attack with mild impairment
- Heart attack – Level D: Heart attack with almost full recovery
- Coronary artery bypass graft
- Stroke – Level A: Stroke with severe impairment
- Stroke – Level B: Stroke with moderate impairment
- Stroke – Level C: Stroke with mild impairment
- Stroke – Level D: Stroke with almost full recovery
- Cancer – Level A
- Cancer – Level B
- Cancer – Level C
- Cancer – Level D
- Kidney failure
- Major organ transplant
- Loss of limbs
- Major burns
- Total Blindness
- Coma
- Multiple sclerosis
- Alzheimer's Disease
- Motor Neuron Disease
- Parkinson's Disease
- Benign Brain Tumour
- Accidental HIV

5. Please elaborate on the nature of the claimant's condition as selected above.

6. What treatment is the claimant undergoing and state the date of first treatment?

D D M M Y Y Y Y

Thank you for your assistance. We wish to advise that we may be requested to provide a copy of this report to other medical practitioners, other insurers and/or legal representatives.

SECTION F: DECLARATION (to be signed and dated by medical attendant)

I hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct. I accept that a copy of this report can be made available to other parties as stated above.

Signed at _____ on this _____ day of _____ 20_____

Name of medical attendant

Signature