zestlife
Cover you can trust.
People you can depend on.

**RETURN ADDRESS AND ZESTLIFE CONTACT DETAILS:**

**E-mail:** info@zestlife.co.za
**Fax:** 021 001 0248
**Post:** PostNet Suite #87, Private Bag X1005, Claremont, 7735
**Tel:** 021 180 4220 / 0860 009 378

## Claim Form

# Assetlife: In respect to a potential permanent disability claim

## SECTION A: INSURED DETAILS

This declaration will form the basis on which your claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Any misstatement could be used as a basis for the claim not being admitted.

Title | Full names

Surname

Date of birth (DD/MM/YYYY) | Gender (M / F) | Identity number

Postal or physical address | Postal code

Cell phone number | E-mail address

Telephone landline number | Policy Number

## SECTION B: NOMINATED CREDIT PROVIDER DETAILS

| Credit provider | Financing agreement account number | Outstanding loan balance | Credit provider contact person name and surname | Credit provider contact person contact number |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Nominated credit provider bank account details

| Credit provider | Bank account number | Branch code | Bank | Type of account |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SECTION C: DISABILITY DETAILS

Date of disability (DD/MM/YYYY) | When did the condition start that caused the disability? (DD/MM/YYYY)

Cause of disability

Was the disability caused by suicide, self-inflicted injury or transgressing any law or as a result of participating in a war or hazardous activities? Yes | No

## **SECTION D:** EDUCATION DETAILS

Highest standard/grade passed

Driver's license codes

Name(s) of universities/colleges or technikons attended

Degrees and/or certificates obtained/or courses passed

Trade certificates obtained

In-house training received

## **SECTION E:** MEDICAL INFORMATION

Conditions for which claiming for

Details of accident causing the injury

Date of accident causing the injury DD/MM/YYYY

Details of any hospitalisations within the last two years

| | | | | |
|---|---|---|---|---|
| **Name of hospital** | | | | |
| **Condition** | | | | |
| **Date of admission** | | | | |
| **Date of discharge** | | | | |

Details of any surgery performed within the last ten years

Current treatment. Please list all medication you are on and the dosages.

## **SECTION F:** DETAILS OF MEDICAL PRACTITIONERS AND REHABILITATION EXPERTS

**General Practitioner or rehabilitation expert**

Full names

Date first seen DD/MM/YYYY

Surname

Postal address

Postal code

Telephone number

Fax number

March 2020

**Specialist**

Full names | Date first seen DD/MM/YYYY

Surname

Postal address | Postal code

Telephone number | Fax number

Speciality

**Specialist**

Full names | Date first seen DD/MM/YYYY

Surname

Postal address | Postal code

Telephone number | Fax number

Speciality

## **SECTION G:** EMPLOYMENT HISTORY

| | **Most recent** | **Previous** |
|---|---|---|
| Date started | | |
| Job title | | |
| Name of employer | | |
| Educational qualifications required for that position | | |
| Broad description of work done | | |
| Date ceased | | |

When do you expect to take up any occupation in the future?

On a part-time basis? DD/MM/YYYY On a full-time basis? DD/MM/YYYY

What is your current employment status? Please tick the appropriate box.

Working full-time ☐ Working part-time ☐

On sick leave ☐ On unpaid leave ☐

Laid off or retrenched ☐ Dismissed ☐

## **SECTION H:** SUPPORTING DOCUMENTATION REQUIRED

**The following documents must be submitted with the claim form:**

1. Copy of the insured ID document. ☐
2. Employer declaration including job description of employee. ☐
3. Medical report completed by the doctor who treated the life insured. ☐
4. Medical reports supporting the permanent disability. ☐
5. Nominated credit provider statements reflecting account details and latest outstanding balance. ☐
6. Copies of certificate/s, diploma/s, degree/s for qualifications obtained listed in Section D. ☐

## **SECTION I:** DECLARATION

I declare to the best of my knowledge that all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted.

I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to Zestlife or any interested party nominated by Zestlife who requires this information for the purpose of assessing my claim.

I hereby authorise Zestlife to furnish any medical information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to any medical practitioner or allied medical practitioner (eg occupational therapist, physiotherapist or psychologist) who may require such information for the purpose of assisting Zestlife in the assessment of my claim.

Signature _____ DD/MM/YYYY

Witness _____ DD/MM/YYYY