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

RETURN ADDRESS AND ZESTLIFE CONTACT DETAILS:
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Post: PostNet Suite #87, Private Bag X1005, Claremont, 7735
Tel: 021 180 4220 / 0860 009 378
Web: www.zestlife.co.za

Claim Form

Cancer Cover

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.

SECTION A: PRINCIPAL LIFE INSURED DETAILS

Title | Full names

Surname

Date of birth DD/MM/YYYY | Identity number

Policy number

Address | Postal code

Cell phone number | E-mail address

Landline number | Medical aid name

Medical aid plan type | Medical aid joining date DD/MM/YYYY

Medical aid membership number

SECTION B: CLAIMANT DETAILS

Full names

Surname

Date of birth DD/MM/YYYY | Identity number

Relation to insured (please tick) Self ☐ Spouse ☐ Child ☐

SECTION C: MEDICAL STATEMENT - THIS SECTION NEEDS TO BE COMPLETED BY THE ATTENDING ONCOLOGIST

Please provide the client with a copy of the pathology report that diagnosed the cancer.

Has the patient been diagnosed with cancer Yes ☐ No ☐

Type of cancer

Date of first consultation with the patient for this condition DD/MM/YYYY

Date first diagnosed with this cancer DD/MM/YYYY

Provide full details of the cancer

Was the patient referred to you by another doctor? Yes ☐ No ☐

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If yes, provide name, address and contact number of referring doctor

Indicate whether any of the following treatment is recommended by an oncologist or registered medical specialist

Surgery	
Radiotherapy	
Chemotherapy	
Specialised cancer medication	
Any other treatment	

Provide details of recommended treatment

Provide details of treatment already administered (treatment description, date and details)

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013

The privacy of our Insured is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

The Insured's Personal Information will be used to assess the claim for the Insured. You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.

Declaration by Medical Practitioner

I hereby certify that the above statements are true in every respect:

Full names and surname

Practice number

Specialisation

Address

Telephone number

Signature _______________________ DD/MM/YYYY

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SECTION D: SUPPORTING DOCUMENTATION REQUIRED

The following documents must be submitted with the claim form:

1. Copy of the principal insured ID document ☐
2. If the claimant is the spouse or child of the principal insured: ☐
   - Spouse – a copy of the spouse's ID document and of the marriage certificate or an affidavit confirming customary marriage
   - Child – a copy of the birth certificate
   - Step child – copy of the marriage certificate or an affidavit confirming customary marriage, ID document of the spouse and birth certificate of the child.
   - Adopted child – copy of the adoption papers and birth certificate of the child
3. Medical aid statement reflecting details of principal insured and claimant ☐
4. Medical report supporting the illness as well as copies of any relevant results and pathology report. If the diagnosis of cancer was made clinically then please submit the clinical evidence of the diagnosis. ☐
5. Proof of principal insured bank account not older than 3 (three) months. ☐

SECTION E: PRINCIPAL INSURED BANK ACCOUNT DETAILS

Full first names of account holder

Surname of account holder

Identity number of account holder

Bank name

Branch name | Branch code

Account number | Account type

SECTION F: DECLARATION BY PRINCIPAL LIFE INSURED

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner and kept for the period prescribed by the Applicable Laws.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:
- to establish and verify your identity in terms of the Applicable Laws;
- to enable Us to fulfil our obligations in terms of this Claim;
- to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
- reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:
- Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
- Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
- Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
- Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent. Such Personal Information provided (voluntarily, unconditionally and specifically) will be utilised by Us or by any appointed third parties, on our behalf, and will be kept for such period as legislated according to the Applicable Laws.

You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

Full names

Surname

Signature ______________________ DD/MM/YYYY

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