

Claim Form

Assetlife: In respect to a potential temporary 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	<input type="text"/>	Full names	<input type="text"/>			
Surname	<input type="text"/>					
Date of birth	<input type="text" value="DD/MM/YYYY"/>	Gender	<input type="checkbox" value="M"/>	<input type="checkbox" value="F"/>	Identity number	<input type="text"/>
Postal or physical address	<input type="text"/>				Postal code	<input type="text"/>
Cell phone number	<input type="text"/>	E-mail address	<input type="text"/>			
Telephone landline number	<input type="text"/>	Policy Number	<input type="text"/>			

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: TEMPORARY DISABILITY DETAILS

Date of temporary disability	<input type="text" value="DD/MM/YYYY"/>	When did the condition start that caused the temporary disability?	<input type="text" value="DD/MM/YYYY"/>
Cause of temporary disability	<input type="text"/>		

Was the temporary disability caused by attempted 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	<input type="text"/>	Driver's license codes	<input type="text"/>
Name(s) of universities/colleges or technikons attended	<input type="text"/>		
Degrees and/or certificates obtained/or courses passed	<input type="text"/>		
Trade certificates obtained	<input type="text"/>	In-house training received	<input type="text"/>

SECTION E: MEDICAL INFORMATION

Conditions for which claiming for	<input type="text"/>
Details of accident causing the injury	<input type="text"/>
Date of accident causing the injury	<input type="text" value="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	<input type="text"/>
Current treatment. Please list all medication you are on and the dosages.	<input type="text"/>

SECTION F: DETAILS OF MEDICAL PRACTITIONERS AND REHABILITATION EXPERTS

General Practitioner or rehabilitation expert

Full names	<input type="text"/>	Date first seen	<input type="text" value="DD/MM/YYYY"/>
Surname	<input type="text"/>		
E-mail address	<input type="text"/>		
Telephone number	<input type="text"/>		

Specialist

Full names	<input type="text"/>	Date first seen	<input type="text" value="DD/MM/YYYY"/>
Surname	<input type="text"/>		
E-mail address	<input type="text"/>		
Telephone number	<input type="text"/>		
Speciality	<input type="text"/>		

Specialist

Full names	<input type="text"/>	Date first seen	<input type="text" value="DD/MM/YYYY"/>
Surname	<input type="text"/>		
E-mail address	<input type="text"/>		
Telephone number	<input type="text"/>		
Speciality	<input type="text"/>		

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? On a full-time basis?

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

Working full-time	<input type="checkbox"/>	Working part-time	<input type="checkbox"/>
On sick leave	<input type="checkbox"/>	On unpaid leave	<input type="checkbox"/>
Laid off or retrenched	<input type="checkbox"/>	Dismissed	<input type="checkbox"/>

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 that the above information is true, that I have withheld no material information and that all relevant documentation is attached to this claim form.

I authorise my medical aid, any hospital, medical practitioner or other person who has attended to me or my dependants, or examined me or my dependants, to furnish to Zestlife, Guardrisk or their authorised representative any information with respect to any illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. Such information could relate to medical information (i.e. PMB details, chronic conditions, claims transaction history, hospital procedures, health records etc.) or benefit information (i.e. plan type, limits, waiting periods, co-payments, self-payment gap etc.)

I further authorise Zestlife, Guardrisk or their authorised representative to share any information obtained as referred to above with my appointed Gap Cover Financial Advisor.

I hereby waive any right to privacy and authorise the Insurer (or its appointed Administrator):

- to obtain from any doctor, registered healthcare practitioner, hospital, medical institution, police station, insurance company or any other person or entity, whom I hereby authorise to give and to disclose, any information which the Insurer requires or deems necessary to facilitate the assessment of the risks and the consideration of this claim for benefits under this Policy arising from this claim application, and;
- to disclose any insurance information (provided by me or on my behalf to any other insurance company, either directly or through a database operated by or for Insurers as a group, at any time and in such detailed, abbreviated or coded form as may from time to time be decided by the Insurer or by the operators of such database; and
- to verify any information provided against other sources or databases;
- to disclose information regarding a specific policy, owner or life insured to any persons or institution provided that the Insurer considers such disclosure necessary in order to assess this claim; and
- where required through the operation of law, to disclose information regarding a specific policy, owner or life insured to regulatory and government agencies.

Signature _____

DD/MM/YYYY

Witness _____

DD/MM/YYYY

SECTION J: PROCESSING OF PERSONAL INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013

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. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.
