CRITICAL ILLNESS BENEFIT CLAIM FORM – MEMBER & EMPLOYER

The information provided in this form will be used by Hollard Group Risk in the assessment of the member's application for critical illness benefits.

It is essential claim forms are fully completed, signed and dated to prevent any unnecessary delays in finalizing the application due to missing or incomplete information. Hollard Group Risk cannot assess the validity of a claim without the appropriate consent. If the member is incapacitated to the extent that would prohibit completion, the form must be completed by the member's caretaker and/or next of kin. We will require an affidavit confirming the member's inability to complete the form.

The information provided must be truthful and accurate. Dishonesty, misrepresentation and/or fraudulent information will result in the claim being declined.

It is the employer's responsibility to compile all the documents required and to submit them to Hollard Group Risk.

Please send the completed claim documentation to hgrdisability@hollard.co.za. Alternatively, information can be posted to PO Box 87419, Houghton 2041 (attention Hollard Group Risk Disability claims). Our contact number is 011 351 5000.

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

- Critical Illness Claim Form - Medical Attendant's Report. The member must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner.
- Copies of diagnostic test results (as per policy criteria).
- A copy of the member's identity document.
- A copy of the member's payslip for the month of diagnosis / event.
- Proof of banking details (e.g. bank statement or signed/stamped account confirmation letter from the bank).

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

SECTION A: POLICY DETAILS (to be completed by employer or member)

Policyholder:

Policy number:

Membership / Employee number:

SECTION B: EMPLOYER'S DETAILS (to be completed by employer or member)

Name of employer / company:

Physical address:

Code

Contact person:

Job title:

Telephone number:

Email address:

SECTION C: MEMBER'S PERSONAL DETAILS (to be completed by employer or member)

First name(s):

Surname:

Identity number:

Date of birth (dd/mm/yyyy):

Gender: Male Female

Residential address:

Code:

Postal address:

Code:

Contact number:

Email address:

Occupation:

SECTION D: MEMBER'S REPORT ON DIAGNOSIS OF CRITICAL ILLNESS (to be completed by member)

1. Which critical illness have you been diagnosed with:

2. Date of the diagnosis (dd/mm/yyyy):

3. Full name of the doctor who made the diagnosis:

4. Doctor's contact number:

5. Have you previously received any benefits from any other insurance company?

Yes (please provide details below) No

SECTION E: BANKING DETAILS (to be completed by member)

Payment will be made to the member only.

Name of account holder:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

SECTION F: MEMBER'S DECLARATION AND CONSENT (to be signed and dated by member)

At Hollard Group Risk we respect the privacy and confidentiality of personal information. We will treat this information responsibly and we have put reasonable security measures in place to protect it.

For the purposes of this consent the following phrases are defined as indicated:

Health Practitioner	Any specialist, doctor or allied health professional (e.g. occupational therapist, psychologist, physiotherapist etc.).
Third Party	Any independent Health Practitioner, medical institution, medical aid, employer, insurance company, health risk management service provider or any other person or institution that has/needs information relating to the assessment and management of this claim.
Relevant Information	Any medical, occupational and personal information needed to assess the submitted claim.

By signing this form, I consent and give permission for:

- Any Health Practitioner and/or Third Party to provide Relevant Information to Hollard Group Risk or any Third Party nominated by Hollard Group Risk who requires this information for the purposes of assessing and managing the submitted claim.
- Hollard Group Risk to (at its discretion) share Relevant Information with any Health Practitioner or Third Party with the purpose of assisting Hollard Group Risk in the assessment and management of the submitted claim as well as to prevent over insurance and fraud in the insurance industry.
- Hollard Group Risk to send claim related correspondence to the Policyholder's appointed contact person(s). Correspondence may include personal and special personal information but will not include confidential medical information.

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 Group Risk.

I confirm that I know and understand the contents of this form and I am providing consent voluntarily.

Signed at _____ on this _____ day of _____ 20 _____

_____

Member's signature

If the form was completed on behalf of the member:

Signed at _____ on this _____ day of _____ 20 _____

BY EITHER:

_____ _____

Caretaker's name / next of kin's name Signature

OR

_____ _____

Employer's name Signature

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

1. Date the member join the company (dd/mm/yyyy):
2. Date the member join the critical illness benefit scheme (dd/mm/yyyy):
3. Month last risk premium was paid for (mm/yyyy):
4. Member's salary as at the date of the diagnosis: R
5. Effective date of the above salary (dd/mm/yyyy):

SECTION H: EMPLOYER'S 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 Group Risk.

Signed at _____ on this _____ day of _____ 20 _____

_____ _____

Name of authorised signatory Designation

_____

Employer's signature