CRITICAL ILLNESS CLAIM

To whom it may concern,

Please find below the critical illness claim form to be completed and signed by the Life Assured. This form as well as the documents listed below, must be submitted to Different Life via email claims@differentlife.co.za or in person.

If in person, please deliver to:
Building A, Bryanston Corner, 18 Ealing Crescent, Bryanston, Johannesburg 2021

REQUIRED DOCUMENTS

To initiate the claim process:

The original or certified copies, signed by a commissioner of oaths, of the following:

1. The insured's ID document.
2. The Personal Medical Attendance form completed by the doctors who are currently treating or who has treated the insured.
3. Medical aid records for the 5 years preceding contract date.
4. A copy of the hospital file.
5. 3 Months Bank statement reflecting Monthly income
6. Completed Application Form

PARTICULARS OF THE INSURED

Policy Schedule Number													
First Names													
Surname											Title	Miss Mrs Mr Dr Prof	
Initials		Gender	Female Male								Language		
ID / Passport / Card Driving Licence Official Number													
Postal Address													
											Postal Code		
Physical Address													
											Postal Code		

Telephone (w)	Fax (w)
Telephone (h)	Fax (h)
Cellphone	Communication Preference Post Fax e-mail
E-mail address	
Medical Aid	Medical Aid Number

CRITICAL ILLNESS DETAILS

Based on the policy conditions and definitions of critical illness, for which illness are you claiming?

Have you submitted a critical illness claim before?	Yes	No

If yes, please provide details and date of claim

	Y Y Y Y M M D D
On what date did the symptoms of the critical illness for which you are claiming for start?	
On what date did you first consult a medical practitioner in connection with your current condition?	
On what date was your critical illness first diagnosed?	

State names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)

A. Doctor	Address
Hospital / Clinic	Ref. No.

	Y Y Y Y M M D D
Date attended	

B. Doctor	Address
Hospital / Clinic	Ref. No.

	Y	Y	Y	Y	M	M	D	D
Date attended								

C. Doctor	Address
Hospital / Clinic	Ref. No.

	Y	Y	Y	Y	M	M	D	D
Date attended								

DETAILS OF THE DOCTOR WHO IS CURRENTLY TREATING YOUR CONDITION

Surname	Initials
Physical Address	
	Postal Code
Telephone (w)	

BANK DETAILS OF THE INSURED

Name of Bank	Branch Name
Account Number	Branch Code
Name of Account Holder	Account Type

Signature of Account Holder	Date	Y	Y	Y	Y	M	M	D	D

DECLARATION AND AUTHORISATION BY THE INSURED

Policy Schedule Number

Declaration

I declare that to the best of my knowledge all the information that I have given in this claim form is accurate and complete and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim.

I acknowledge that I fully understand the contents of this declaration.

Authorisation

I hereby authorise any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I further authorise any of its representatives to release any information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed _____

Signature of Claimant _____

	Y	Y	Y	Y	M	M	D	D
Date								