

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

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Postal Address

Postal Code

Physical Address

Postal Code

DIFFERENT LIFE (PTY) LTD

Different Life is an authorised financial services provider | FSP No. 45453 | [w differentlife.co.za](http://differentlife.co.za) different.org | [e info@differentlife.co.za](mailto:info@differentlife.co.za)

Building A, Bryanston Corner, 18 Ealing Crescent, Bryanston, Johannesburg, 2191 | Box 3812, Dainfern, 2055 | [t 010 020 1921](tel:0100201921)

Directors: A. G. Tomlinson (Executive), P. N. Tomlinson (Executive), V. Daljee, A. Lester | Reg. No. 2014/023254/07

The underwriter of this policy is Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.

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
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If yes, please provide details and date of claim

On what date did the symptoms of the critical illness for which you are claiming for start?	Y	Y	Y	Y	M	M	D	D
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.						
Date attended	Y Y Y Y M M D D						

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

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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

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