Sanlam Risk Benefits

Claim for Income Protector / Overhead expenses Protector

Please return the completed form to: **Policy claims**

Postal address	PO Box 1, Sanlamhof 7532	Telephone number	(021) 916-3455
E-mail address	claimbenefits@sanlam.co.za	Fax number	(021) 947-5804

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.
- It is also important that you should be aware of the implications of the non-payment /payment of this claim for your financial position. We therefore strongly recommend that at this stage you should already contact your financial advisor to assist you in this regard.
- This form and all relevant documents can be send to us by e-mail, fax or per post. If readable copies of documents are provided to us, the original documents are unnecessary.

Please supply the following documents:

- If self-employed or if your claim is for the Overhead Expenses Protector benefit, please complete form *Overhead expenses questionnaire*
- If you're self-employed, provide us with proof of existence of your business, for example audited financial statements or tax assessments and statements, receipts or affidavits from persons with whom business have been done.
- A copy of your identity document.
- Copies of all medical reports including those by which you were medically boarded.
- SAPD-report/Reports of injury sustained at work if claim was caused by an accident, as well as the result of the investigation if already finalised.
- Curator Bonis appointment, if the claimant are not able to handle his/her own interest.

Particulars of insured life

Plan number(s) _____ _____ _____

_____ _____ _____

Surname _____

Full first names _____

Date of birth ____/____/____ *(dd/mm/ccyy)*

Identity number _____ *(Compulsory)* Land of issue _____

Pass port number _____ Expiry date ____/____/____ *(dd/mm/ccyy)*

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev ☐ Dr. ☐ Prof. ☐ Adv. ☐ Judge ☐

Gender Male ☐ Female ☐

Postal address _____ Postal code _____

Residential address _____ Postal code _____

Contact details: Telephone (home) (____) _____ Fax (home) (____) _____

Telephone (work) (____) _____ Fax (work) (____) _____

Cell phone _____

E-mail address _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Race White ☐ Asian ☐ Coloured ☐ Black ☐ Unknown ☐ *(For statistical purposes)*

Income office _____

Income tax number _____

Plan number _____

Nature of claim (functional impairment)

- What illness, injury of disorder gave rise to your claim?

  _____

- On which date did you consult a doctor regarding these symptoms? ____/____/____ *(dd/mm/ccyy)*
- State the initials, surname, address and telephone number of this doctor.

  _____

  _____

- Describe the symptoms which you are experiencing and state the date the symptoms began:

  _____

  _____

- Give a brief description of how the symptoms you mentioned in 2.4 have limited your ability to work:

  _____

  _____

- How do you spend your time? _____
- Describe in what respect you have in any way been impeded in attending to your personal interest or in carrying out the everyday care of your person:

  _____

  _____

  _____

Medical history

- State the initials, surname, address and telephone number of your:
  - Present family doctor _____

    Telephone number (____) _____ Fax number (____) _____
  - Previous family doctor _____

    Telephone number (____) _____ Fax number (____) _____
- Since which date have you been consulting your present family doctor? ____/____/____ *(dd/mm/ccyy)*
- State the date when you last consulted your family doctor. ____/____/____ *(dd/mm/ccyy)*
- Provide the following information with regard to all other doctors/specialists you have consulted regarding the condition that caused the claim.

Details for hospitalisation for special investigations or treatments

Name of hospital	Reason for hospitalisation	Patient number	Admission dd / mm / ccyy	Discharge dd / mm / ccyy
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Details of doctors, specialists and consultations

Name and surname	Type of specialist	Address	Telephone number	First consultation dd / mm / ccyy
			( )	/ /
			( )	/ /
			( )	/ /
			( )	/ /

Plan number _____

Medical history *(continue)*

Public health sector

Name and surname	Type of specialist	Address	Telephone number	First consultation dd / mm / ccyy
			( )	/ /
			( )	/ /
			( )	/ /
			( )	/ /

- Medical Aid details:
  - Name of the fund _____
  - Membership number _____

Accident particulars

- Date of accident ____/____/____ *(dd/mm/ccyy)*
- Place of accident _____
- The disability was caused by ☐ Motor vehicle accident ☐ Accident at home ☐ Accident at work ☐ Shooting accident ☐ Other *(specify)* _____
- Give a brief description of how the accident happened:

_____

_____

_____

- If there was an investigation into the cause of the accident, provide the following:

  Name of police station _____

  Case number _____

  Initials and surname of investigating officer _____

  Contact details Telephone number ( ) _____ Fax number ( ) _____

  Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report):

_____

_____

- Did you suffer any physical loss? Yes ☐ No ☐

  If "Yes", describe the nature of the loss you suffered

_____

  If the loss did not happen on the date of the accident, please state the date ____/____/____ *(dd/mm/ccyy)*

Occupational history

- Provide a detailed statement of your career, including your present or last occupation. The exact dates(at least month and year) of the commencement and termination of your service are required.

Name of employer	Address	Telephone number	Commencement dd / mm / ccyy	Termination date dd / mm / ccyy	Nature of work
		( )	/ /	/ /	
		( )	/ /	/ /	
		( )	/ /	/ /	
		( )	/ /	/ /	

Plan number _____

Occupational history *(continue)*

- What was the last date on which you were actively able to do your work? ____/____/____ *(dd/mm/ccyy)*
  (Not necessarily the date of termination of service.)
- Date of official discharge ____/____/____ *(dd/mm/ccyy)*
- Describe the most important functions of your occupation(s) from which you earned an income immediately before your disability. *(from the date of official discharge)*

_____

- State the percentage of time engaged in the actions below as well as the nature of it.

Administrative duties	____ %	_____
Manual / physical duties	____ %	_____
Supervisory duties	____ %	_____
Travelling by car, truck, etc.	____ %	_____
Walking and standing	____ %	_____
TOTAL	100 %	*(Note: The percentages must add up to 100%.)*

- What is your highest educational qualification? *(e.g. St.10/Gr. 12 or B.Com)* _____
- At which school or institution did you qualify? _____
- Any other qualifications obtained? _____
- Any skills and/or courses acquired or passed while in service? _____
- Any study area / business qualifications? _____
- If you are doing any work at present, from which you are earning an income, state the type of work and the income earned:

_____

Provide the name, address, telephone and fax numbers of the relevant employer:

_____

Telephone number (____) _____ Fax number (____) _____

- If you are not working at present, do you intend to do so in the future? Yes ☐ No ☐
- If "Yes", what type of occupation do you have in mind and from which date? From (dd/mm/ccyy)

_____

- If "No", in your opinion, what prevents you from performing full-time employment?

_____

_____

Income particulars

- What was your gross monthly income during the last 12 months before the onset of your disability? (Please indicate any overtime payment separately.)

  Bruto R _____ Overtime R _____

- Provide the following information if, owing to or during your disability you are receiving, or are entitled to receive any benefit, salary, pension or remuneration of any kind (this includes money received from any employer, partner, assurance company, pension or retirement annuity fund, any government fund of from any other source – irrespective of whether a claim has been submitted):

Source of benefit / name of company	**Amount (R)**	**Frequency of payment**	**Inception date** dd / mm / ccyy	**Cessation date** dd / mm / ccyy
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Important

Fill in this section only if you were self-employed. Please provide us with proof of existence of your business.

Plan number _____

Income particulars *(continue)*

- What were your operating costs for the 12 months prior to disability?

_____

- What will happen to your business now that you are disabled?

_____

- If you are continuing with your business, what is your Involvement *(e.g. how are you involved in running the business and what is your share of the profit)?*

_____

- What duties did you do before your disability?

_____

_____

- What duties do you still do after your disability?

_____

- Have you had to appoint people to continue running your business? Yes ☐ No ☐
- If "Yes", at what cost has this been done? *(Please attach documentary evidence such as salary statements.)*

_____

Payments

Please note that the payments must be continued until a claim, if any, has been admitted.

Bank particulars

Please complete **one** of the 3 options provided

1. Payment to the owner of the plan(s).

If your claim is admitted, Sanlam Life can make your money available by means of an electronic bank transfer. Please provide us with the following details:

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(Specify)*

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of account holder _____

Date ____/____/____ *(dd/mm/ccyy)*

2. Payment to cessionary

Important
If any plan in terms of which a claim is admitted, has been ceded to another institution or person, payment will be made directly to the cessionary in question. The next section must be completed by the cessionary if applicable.

Complete if any of your policies are ceded:

Relevant plan number(s) _____ _____ _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(Specify)*

Or

I hereby give permission for the cession to be cancelled: _____

Name of contact person _____ Contact number: (____) _____

Signature of cessionary _____ Official stamp of institution
Signature of cessionary _____

Date ____/____/____ *(dd/mm/ccyy)*

Plan number _____

Bank particulars *(continue)*

3. Proxy and/or payment to a third party

If you would prefer your claim/payment to be handled/received by another person/institution, please provide us with the details below:

I, (plan owner) first names and surname: _____

Hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Sanlam Life against any and all claims in respect of, and in connection with, the payment by Sanlam of the amount(s) concerned to this third party. (delete where not applicable)

Initials and surname of the person that could handle the claim on my behalf: _____

Address _____ Postal code _____

Initials and surname of the person that could receive the payment on my behalf: _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(Specify)*

Signature of plan owner _____

Date ____/____/____ *(dd/mm/ccyy)*

Declaration

I declare that the particulars contained in this form are correct. I also irrevocably authorise any person or institution, medical practitioner, medical specialist, hospital, nursing institution or medical authority to provide Sanlam Life with any information that may be required regarding my health.

Further, I irrevocably authorise Sanlam Life to share with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Sanlam Life or by the operators of such data base.

Signature of insured/claimant _____

Date ____/____/____ *(dd/mm/ccyy)*