Hollard.

CRITICAL ILLNESS CLAIM FORM

(To be completed by the Life Insured)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

The following must be included when submitting this form:

a. A certified copy of the claimant's identity document (within 3 months)
b. Proof of bank account details of the claimant (e.g. copy of original bank statement within 3 months)
c. Proof of residence if address is not on the bank statement (within 3 months)

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

If the policyholder is a Company, Close Corporation, Partnership, Sole Prop, Trust or Unincorporated Entity, please complete the FICA Form.

1. Life Insured's details

Policy no. _____ Identity no. _____

Name of Life insured _____

Date of birth | D | D | M | M | Y | Y | Y | Y | Work tel. no. _____

Home tel. no. _____ Cell no. _____

Email address _____ Mandatory

Physical address _____ Postal code _____

Postal address _____ Postal code _____

Country of residence _____

Employer's name _____

Occupation _____

2. Claim details

2.1 Dread disease claim in respect of: _____

2.2 Date of onset of illness or injury which led to the claim | D | D | M | M | Y | Y | Y | Y |

2.3 Duration of illness or injury _____

2.4 Give detail of any other dread disease benefit that you have received or expect to receive or applied for as a result of your dread disease. Provide details in the table below:

Source of benefit (state name of company and your reference no.)	**Type of benefit** (e.g. Insurance, lump sum)	**Amount**
		R

2.5 Please supply the names and addresses of all doctors and specialists who attended to or prescribed medication for the person insured during the two years preceding the circumstances that led to the claim.

3. Illness of the Life Insured

3.1 Describe in detail the cause of the illness

3.2 Describe in detail the extent of the illness

3.3 What treatment are you undergoing?

3.4 Date of first treatment D D M M Y Y Y Y

3.5 Have you been hospitalised YES ☐ NO ☐

If YES, please specify

Date of admission D D M M Y Y Y Y

Date of discharge D D M M Y Y Y Y

3.6 Are you under medical care at present? YES ☐ NO ☐

If YES, please supply the name and address of the medical practitioner

Name

Address

4. Declaration by Life Insured

The following declaration must be made by the Life Insured unless he/she is totally incapable of understanding or attending to it. In such event the declaration is to be made by such person holding a Power of Attorney to make the declaration on the Life Insured's behalf. A copy of the Power of Attorney must be attached to this form.

I, the Life Insured, do hereby declare that all the aforementioned answers are true, that nothing required by Hollard Life Assurance Company (hereafter referred to as the Company) to assess any liability for payment of the policy benefits has been withheld or concealed and that I may be medically examined, if required, at the discretion of the Company.

I agree that these and all statements that I as the person insured have made or shall make to the Company in connection with this claim and on the proposal of the policy shall be the basis for the assessment of this claim.

I consent to the Company seeking medical information from any doctor or institution who at any time has attended to me or seeking information from any office to which I have at any time made a proposal for life or sickness or accidental insurance, or from my employer, or from any other person on anything relating to this claim. I authorise the giving of such information, including the results of any blood tests, and I agree that this authority shall remain in force after my death.

Where warranted by a change in my condition I understand and agree that the Company has the right to cease any further benefit payments and recover any benefits paid for which I was not eligible and I do further declare that if relevant to this claim I was in no way under the influence of intoxicating liquor or drugs when the accident occurred.

Please take note of the following Hollard disclosures:

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identify (and in many cases the identities of related persons, such as but not limited to directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signed at _____ Date | D | D | M | M | Y | Y | Y | Y |

Life Insured signature _____ **Witness signature** _____