Claim for Trauma benefit

Contents

The following forms must be completed for the submission of a trauma claim.

The forms consist of:

- Trauma claim: Declaration by fund/scheme - Form to be completed by employer.
- Statement by insured for a trauma claim - Form to be completed by the claimant.
- Questionnaire to doctor: Trauma - Form to be completed by claimant's treating specialist as well as the compiling of the report.

Very important: If there are any existing specialist reports available please forward copies with the claim documents.

General

- The claimant has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.
- The claimant is obliged to submit whatever medical or other information Sanlam may reasonably require.

The employer must either post, fax or e-mail the duly completed forms.

Mark with (X) or provide relevant answer:

	Trauma Claim: Declaration by fund/scheme (Page 2)
	Statement by insured for a trauma claim (Page 3- 4)
	Questionnaire to doctor: Trauma (Page 5-8)
	Medical report by doctor
	Existing Specialist reports (if available)
	Incident Date (Page 5)
	Salary statement as at incident date
	Copy of the insured's Identity Document
	Bank verification of beneficiary
	FIA Form 2 (Natural Person)
	Motivational Letter should the be submitted after 6 months of the incident date, without prior notification.

Note: Please do note that all required documentation must be submitted and received as a complete package before the claim process can be initiated

Trauma Claim: Declaration by fund/scheme

Particulars of fund/scheme

Name of fund/scheme _____ Code _____

E-mail of contact person _____ Telephone number _____

Postal address _____

_____ Postal code _____

Name of branch/participating employer _____

Particulars of the member/insured

Full first names and surname _____

Date of birth _____ Gender _____ Marital status _____

Occupation _____ Identity number _____

What illness, impairment has led to this claim? _____

_____

Particulars of membership

Membership no _____ Pay-sheet no. (If any) _____

Date of entering service _____ *(dd/mm/ccyy)* Date of permanent appointment _____

Date of commencement of membership _____ *(dd/mm/ccyy)*

Annual pensionable remuneration of member		Date granted
i. On fund/scheme anniversary before traumatic incident:	N$	
ii. On date of traumatic incident	N$	
iii. One year immediately before traumatic incident	N$	

If (ii) differs from (i), state the date of the increase. _____ *(dd/mm/ccyy)*

Did the member/insured qualify for membership of the fund/scheme on the date of commencement of trauma? Yes ☐ No ☐

We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.

Signature on behalf of the fund/scheme

Signature _____ Designation _____

Signature _____ Designation _____

Date _____ *(dd/mm/ccyy)* Place _____

Statement by insured for a trauma claim

Name of fund/scheme _____

Name of insured _____

Insured's date of birth _____ *(dd/mm/ccyy)* Telephone number _____

Membership number _____ Cell Phone number _____

Identity number _____ E-mail address _____

Nature of illness or impairment

1.1 Name and address of your regular family doctor

_____

_____ Postal code _____

1.2 Since what date has he/she been your family doctor? _____ *(dd/mm/ccyy)*

1.3 Mention date of last consultation. _____ *(dd/mm/ccyy)*

1.4 Who was your previous family doctor? _____

1.5 Which illness or impairment has led to this claim? _____

_____

1.6 On what date did you see a doctor about this for the first time? _____*(dd/mm/ccyy)*

1.7 What was the name of this doctor? _____

1.8 Please state the names of all other doctors you have consulted in this regard.

_____

_____

_____

1.9 If this claim resulted from an accident, please give the following information:

1.9.1 Date of accident _____ *(dd/mm/ccyy)*

1.9.2 Circumstances causing the accident.

_____

1.9.3 If a formal enquiry was conducted, please state by whom and what the result was.

_____

_____

_____

_____

_____

General

Do you have trauma assurance with other companies too? Yes ☐ No ☐

If "Yes", Name of company _____

Sum assured N$ _____ Inception date _____*(dd/mm/ccyy)*

Please give any other information which, in your opinion, may influence the claim.

_____

_____

_____

_____

_____

Payment of benefits

Personal information

Postal address _____

_____ Postal code _____

Residential address _____

_____ Postal code _____

Telephone number(s) (work) _ (home) _____

If the benefits are to be paid into the beneficiary's bank account, please provide us with a cancelled cheque or a certified deposit slip in the case of a savings account as well as the following information:

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account Cheque/current ☐ Savings ☐ Transmission ☐

Consent for Disclosure of Confidential Information and Declaration

I, _____ *(full name(s) and surname of insured)*

(Identity number) _____ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess (and review) my disability. This includes my previous medical history as well as any psychological or psychiatric records for the purpose of determining my ability to perform work.

I also declare that I have no objections to my medical information being supplied to and obtained from, either directly or through a data base operated by or for insurers as a group, Sanlam's medical advisor, the employer, fund, ombudsman, legal representatives, other insurers, reinsurers and/or the medical service providers involved in the disability assessment and rehabilitation processes if necessary, for the purposes of underwriting risks or assessment and review of any claim for benefits under a policy.

I also irrevocably authorise any medical practitioner, medical specialist, health professional, hospital, medical scheme, or any other person or institution who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I accept and understand that I am limiting my right to privacy to the extent permitted by me in this authorisation, to facilitate the validation and assessment (and review) of my disability claim under the group insurance policy, or any other reason including detection and prevention of fraudulent claims. I acknowledge that I cannot cancel this authorisation and that it will endure even after my death.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

I declare that I am the person described above and that the replies given to the questions are true and correct.

Signature

Signature _____

Witness _____

Date *(dd/mm/ccyy)* _____ Place _____

Questionnaire for doctor: Trauma

Name of fund/scheme _____

Membership no _____

Name of branch/participating employer _____

Name of claimant _____

Insured's date of birth _____ *(dd/mm/ccyy)* Identity number _____

Dear Doctor

Please provide us with the information requested below. The claimant has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.

A General (To be completed at all times)

Are you the insured's family doctor? Yes ☐ No ☐

- If you are, from what date is the claimant your patient? _____
- If not, please give his/her name if known to you.

_____

Please give full details of previous or other abnormal physical or mental conditions about for which you have been consulted.

Nature	Date of consultation *(dd/mm/ccyy)*	Duration

Please state the name and address of any other doctor the insured consulted.

Doctor	Condition	Date of consultation *(dd/mm/ccyy)*	Duration

Date on which condition was diagnosed / Date of the loss / Date of the incident _____ *(dd/mm/ccyy)*

Date of first consultation _____ *(dd/mm/ccyy)*

B Minimum medical requirements for the insured's illness

Important The insured can only claim for the illnesses listed in the relevant contract and not all the illnesses listed below.

Cancer
- Up to date clinical report from the treating medical specialist
- Pathology report(s)

Myocardial infarction
- Clinical report including date of diagnosis, extent of infarction (transmural or sub-endocardial)
- All ECG's available (old and new)
- Serial Cardiac enzymes (CK, CK-MB fraction): copy of lab reports
- Cardiac markers (e.g. trop T)
- Other: Reports of echocardiogram, angiogram

Stroke
- Clinical Report after maximal medical improvement has been reached indicating permanent neurological impairment
- Copy of brain scans

Coronary artery bypass surgery
- Cardiologist report
- Operation report

Heart valve replacement
- Cardiologist report
- Operation report

Aortic artery surgery
- Surgeon report
- Operation report

Arrythmia
- Up to date cardiologist report
- Operation report regarding pacemaker, defibrillator or ablation

Cardiomyopathy
- Up to date cardiologist report including the ejection fraction and exercise test to determine amount of METS reached on maximal exercise
- Echocardiography

Blindness
- Ophthalmologist report with visual acuity before and after correction
- Visual fields where applicable

Organ transplant
- Specialist report
- Operation report

Chronic renal failure
- Clinical report indicating period of dialysis
- Up to date kidney functions (blood tests)

Sero-positive rheumatoid arthritis
- Rheumatologist report with details of treatment administered
- Blood tests (rheumatoid factor)

Multiple sclerosis
- Up to date neurologist report, with details of chronological progression of disease
- Special investigations: scans

Parkinson's disease
- Neurologist report

Loss of limb function
- Clinical report indicating diagnosis, amputation level, range of movement, power, sensation, deformities
- X-rays, EMG, Doppler studies (where applicable)

Benign brain tumor
- Clinical report indicating neurological impairment
- Scans
- Pathology reports

Pulmonary embolism
- Clinical report
- Ventilation-perfusion scan (VQ)

Total deafness
- Clinical report
- Oudiogram with speech discrimination

Accidental HIV infection
- Clinical report
- Injury report or Police report
- HIV blood tests: results of claimant and patient involved in injury/incident
- Pre-seroconversion proof of negative HIV status

Alzheimer disease
- Clinical report from psychiatrist indicating DSM diagnosis and restrictions of activities of daily living
- Copies of psychometric tests done

Motor neuron disease
- Up to date neurologist report

Muscular dystrophy
- Neurologist report including description of functional impairment

Aplastic anaemia
- Haematologist report
- Bone marrow report

Coma (more than 96 hours, not medically induced)
- Detailed clinical report of the causes, diagnosis, reason for ventilation, clinical progression, time of ventilation and parenteral feeding
- Glasgow coma scale on admission and during ventilation
- Copies of all hospital records

Major burns
- A detailed description of third degree (not first and second degree) burn wounds is needed. (% of body surface affected)
- Cause and date of incident
- The attached diagram can be used to show the extent of the third degree burns.

Liver failure
- Clinical report from treating specialist
- Copies of special investigations done (e.g. liver function tests, liver biopsy)

End stage lung disease
- Clinical report from pulmonologist or physician
- Lung function tests, diffusion capacity (DCO)

Medical practitioner's information and signature

Initials and surname _____

Practice number _____ Qualifications _____

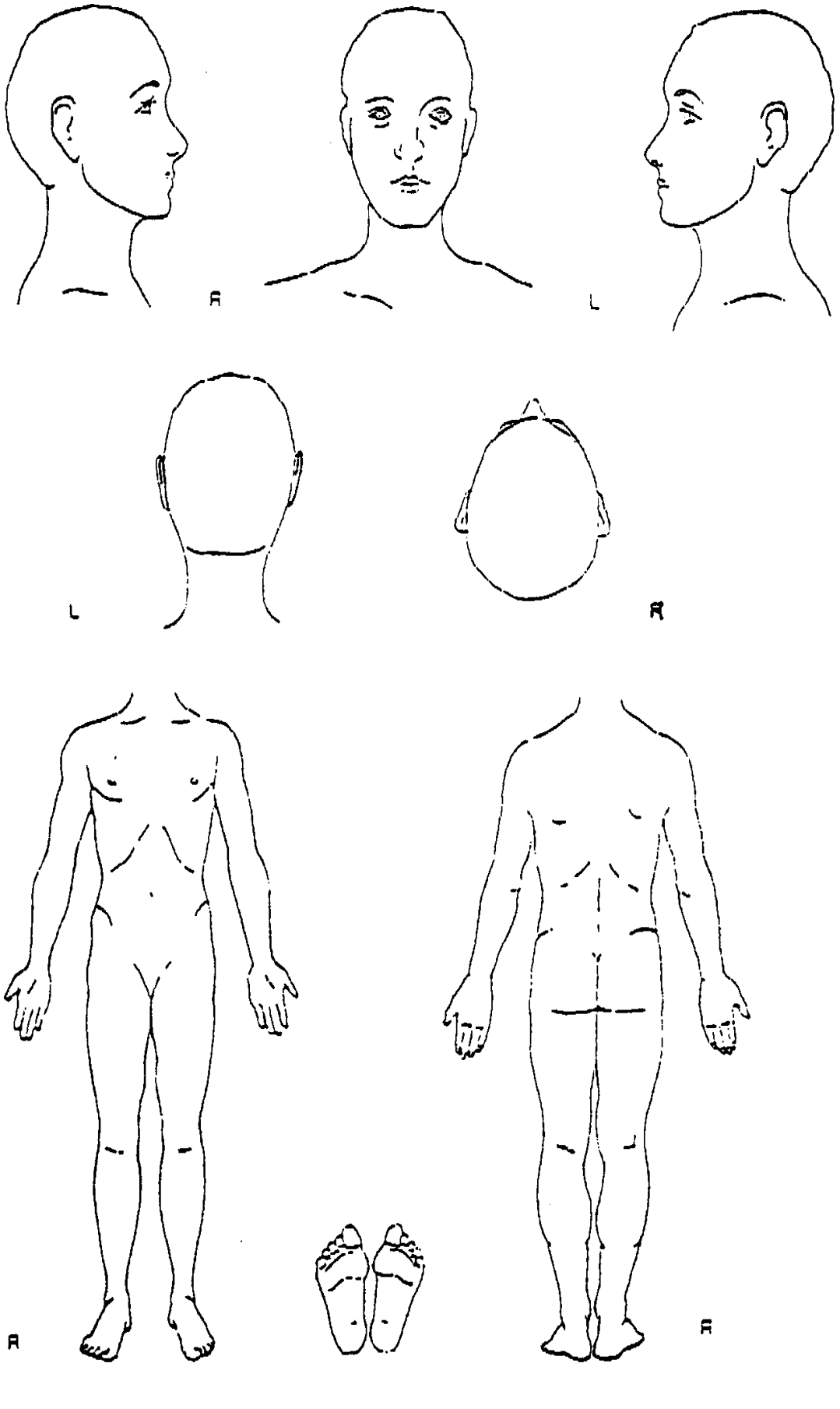
Address _____

_____ Postal code _____

Telephone number (home) _____ (work) _____

Signature _____

Date _____ *(dd/mm/ccyy)*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Sanlam | Allianz

FIA IDENTIFICATION FORM: 2

NATURAL PERSON / INDIVIDUAL (Namibian & Foreign)

Account nr (investment / policy):_____
Role (e.g. client / payer):_____

A. INFORMATION REQUIRED:

1. Full names:	
2. Previous names:	**3. Date of Birth (minor only)**
4. Surnames:	
5. Nationality (country of birth)**:**	6. Citizenship:
7. ID nr:	**8. Valid Passport nr:**
9. *Occupation:*	10. Country of residence:
11. Net amount of monthly income N$:	12. *Principal source of income*:
13. Source of funds:	14. *Source of wealth*:
15. Additional sources of income:	16. Other investments or policies held at Sanlam Allianz:
17. Purpose of business relationship with Sanlam Allianz:	18. Telephone:
19. Employer:	*20. Cell phone:*
21. Postal address:	
22. Email address:	
23. Residential address (street number, street name, town/city, country):	
24. Residential address in foreign country (if not Namibian):	
25. Country of tax residency:	*26. Tax reference number:*
27. Business activities:	*28. Name of business*:
29. Location of business activities (street address):	

B. VERIFICATION DOCUMENTS REQUIRED:

1 □ **Identity Document; or**
□ **Valid Passport.**
□ **Birth Certificate - acceptable for a minor (below the age of 18 years) only.**
2 □ **If applicable - Proof of Authority for representative e.g. Power of Attorney / Court Order.**

C. FOR EACH CONNECTED PARTY (If an individual, see FIA Form 1 for information & documents required):

1 □ **Representative (acts on behalf) of the natural person** (e.g. parent / guardian of minor, individual holding a Power of Attorney, curator)**.**
2 □ **Beneficial owner (individual on whose behalf a transaction is concluded) of the natural person.**

Declaration:
I, _____ (full names and surnames): hereby confirm that the above information is true and correct.

_____ **Signature** _____ **Date**

or declaration by intermediary (Broker / Person contracted by Sanlam Allianz / Sanlam Allianz employee):

I, _____ (names and surnames) with ID nr: _____ and with Sanlam Allianz code: _____, hereby confirm that I have established the identity of this person as required by the FIA. I have seen the original (or certified copies of the original) verification documents.

_____ **Signature** _____ **Date**

**Source of Wealth: How was most assets aquired? For example, it could have been from: Salary income, inheritance, business income, retirement, divorce settlement, investment proceeds, policy proceeds and/or sale of immovable property etc.*