momentum

Critical illness claim form

(General)

(To be completed by client and medical doctor)

Policy number	1	2	3	4	5	6	7	8	9	0

You have a say in how Momentum treats your personal information. We abide by confidentiality principles and the Protection of Personal Information Act. You voluntarily give us your consent to collect, record, store and use (process) your information including special information for the purposes of processing and assessing this claim, and related transactions and to share it with our partners and contracted service providers who are legally bound to the same principles. Your personal information is collected and processed by our staff, representatives, reinsurance partners or sub-contractors. We will make every reasonable effort to protect and secure your personal information. To assess your claim, we may need to share your information with others in the Momentum Metropolitan Group or contracted service providers (both locally and abroad). Momentum Metropolitan Group will make sure that the contracted service providers agree to our privacy and security policies if they need access to your personal information for claims and statistical purposes.

You can access your information at any time and ask us to change or correct it. You may object to us using your personal information except when we need it to conclude business transactions with you, or to fulfil our legal obligations. You also have a right to request that we delete your personal information in our possession if we no longer legally require it. If you think your personal information is being tampered with, or that it has not been protected, please refer your complaints to our internal data privacy team at **dataprivacy@momentummetropolitan.co.za.** Should you not be satisfied with the outcome, you may refer your case to government's Information Regulator at **inforeg@justice.gov.za** or contact them on **012 406 4818.**

Contact details

To submit a claim, follow up on a claim, or to provide us with additional required documentation, you can contact us in any of the following ways. Our office hours are from 8:00 – 17:00.

E-mail: **lumpsumclaims@momentum.co.za**
Fax: **+27 12 675 3947** (Please quote the policy number on the fax.)

Or call us for more information:

Sharecall (South Africa): **0860 44 11 11**
Tel: **+27 12 675 3052**
International: **+27 11 505 1552**

This form is relevant for the following claims only:

A. Connective tissue diseases ☐	B. Musculoskeletal system ☐	C. Gastrointestinal system ☐
D. Urinary tract ☐	E. Respiratory system ☐	F. ENT system ☐
G. Visual system ☐	H. HIV/AIDS ☐	I. Terminal illness ☐
J. Severe aplastic anaemia ☐	K. Major burns ☐	L. Catch all ☐
M. Trauma ■	N. Endocrine and metabolic diseases ☐	

Please complete a *Critical illness claim form* (CLAIM 008) for Cardiac and arterial system, Cancer or Nervous System critical illness claims. All relevant questions are to be completed in full. All supporting documentation must be attached to the report.

Please note: Any individual who knowingly provides false, incomplete or misleading claim information to an insurance company is guilty of insurance fraud which is punishable by law.

Requirements

In order for Momentum to process your claim, the following is required:

Insured life

Complete the following sections on this form	1, 2, 3, 4
A certified copy of the insured life's identity document	✓
A copy of a bank statement in the name of the policyholder	✓
A certified copy of the e birth certificate confirming the biological parent(s) noted on the birth register*	✓
The adoption papers for claims in respect of a legally adopted child*	✓

* These documents are only required if the critical illness claim is for a child.

Requirements (continued)

Medical doctor

Complete the following sections on this form	5 and 6

Preferred communication

As part of our claim's process we will keep your servicing financial adviser on our system informed of the progress of the claim.

Should you not wish the servicing financial adviser to remain informed of the progress of the claim, please indicate with a tick. ☐

In the event that you selected the above option, you will be responsible to submit all claim documentation to Momentum directly.

Name and surname	Ethan Klein
Signature	
Date	03 05 1997

1: Details of insured life

Title	Mr	Initials	EK
First name	Ethan		
Surname	Klein		
Identity number (RSA residents only)	1234569999999	Permanent ID	Yes ■ No ☐
Passport number (non-RSA residents only)		Date of birth	05 03 1997
Passport expiry date	DD MM YYYY		
Passport country of issue			
Postal address			
		Postal code	7441
Telephone - work		Telephone - home	
Cellphone number	0824957633		
E-mail address			

2: Request to medical specialist, hospital or clinic

Which hospital was the insured life treated at			
Treatment date	DD MM YYYY	File number	
Doctor's name			
Doctor's address			
		Postal code	
Telephone - work			

3: Medical history

Details of referring doctor

Name of doctor who referred the patient	
Telephone number	

Has the patient consulted any other medical practitioner or has he/she been hospitalised? Yes ☐ No ☐

If "yes", indicate the name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s):

Name	Address	Illness	Date	Duration

3: Medical history (continued)

Details of referring doctor (continued)

Is the patient a member of a medical aid? Yes ☐ No ☐

Name of medical aid

Member number

Name of main member

4: Disclaimer

Momentum will take all reasonable steps to ensure the security and confidentiality of the information submitted. Momentum also ensures the integrity and security of its electronic data systems and warrants that it will comply with all relevant legislation relating to electronic communications. However, Momentum will accept no liability for loss or damages of any nature resulting from:

- Your negligent usage of this electronic platform for transactional purposes or that of your Representative.
- The claim data being incorrectly captured by you or on your behalf.
- The payment details or the payee details being incorrect.

5: Declaration by insured life

I accept that I am personally responsible for the cost of this examination and any other supporting reports or documentation required by Momentum to process the claim.

The policyholder/insured life accepts and understands the limitation of their right to privacy by signing this claim form. To enable the assessment of any claim for benefits, the policyholder and/or the insured life authorises Momentum to:

- Obtain from any person, other insurer, medical aid, medical practitioner/institution, or any other company/companies, any information that Momentum requires for assessing and processing this claim. The policyholder/insured life authorises such person(s) to give the information to Momentum;
- Share with other insurers for the purposes of assessing and processing the claim, any information in this form or in any related policy or other document, either directly or through a database operated by or for insurers as a group and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- Disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

Signed at

Signature of insured life

Date D D M M Y Y Y Y

6: Details of the insured life's medical condition (to be completed by the medical practitioner)

Indicate the illness/procedure being claimed for in the appropriate section and attach the relevant reports/ investigation results as indicated or any other supporting information/ documentation that you believe may be relevant, in order to assess the claim.

A. Connective tissue diseases ☐

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes ☐ No ☐
- Muscle/tissue biopsies Yes ☐ No ☐
- CT Scans Yes ☐ No ☐
- MRI Scans Yes ☐ No ☐
- Ultrasounds Yes ☐ No ☐
- Other procedures/investigations Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

Is there any joint/organ involvement (specify)?

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

A. Connective tissue diseases (continued)

List the names and duration of all medication used:

B. Musculoskeletal system ☐

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

Is there any joint/organ involvement (specify)?

List the names and duration of all medication used:

C. Gastrointestinal system ☐

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Gastroscopic or Colonoscopic procedures — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

Has the insured life experienced any weight loss? Yes ☐ No ☐

If "yes", specify:

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

C. Gastrointestinal system (continued)

List the names and duration of all medication used:

D. Urinary tract

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

List the names and duration of all medication used:

E. Respiratory system

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Please provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Lung function tests — Yes ☐ No ☐
- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

E. Respiratory system (continued)

List the names and duration of all medication used:

F. ENT system

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Hearing tests — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

List the names and duration of all medication used:

G. Visual system

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Visual acuity testing — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

G. Visual system (continued)

List the names and duration of all medication used:

H. HIV/AIDS

Date of diagnosis D D M M Y Y Y Y

Is the insured life claiming for HIV? Yes ☐ No ☐

Is the insured life claiming for AIDS? Yes ☐ No ☐

If "yes", we will send you a list of reports required for us to assess the claim.

I. Terminal illness

Date of diagnosis D D M M Y Y Y Y

What is the cause of the terminal illness?

- Provide up to date medical report including diagnosis, severity, prognosis and treatment plan.
- What is the current life expectancy of the life insured?
- Supply reports of all investigations and procedures performed which are relevant to the final diagnosis.

J. Severe aplastic anaemia

Date of diagnosis D D M M Y Y Y Y

Provide up to date medical report including severity, prognosis and treatment plan.

Has the life insured undergone any of the following?

- Blood transfusion Yes ☐ No ☐
- Received marrow stimulation Yes ☐ No ☐
- Received immunosuppressive agents Yes ☐ No ☐
- Bone marrow transplant Yes ☐ No ☐

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes ☐ No ☐
- Muscle/tissue biopsies Yes ☐ No ☐
- CT Scans Yes ☐ No ☐
- MRI Scans Yes ☐ No ☐
- Bone marrow aspirates/trephines Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

List the names and duration of all medication used:

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

K. Major burns ☐

Date of diagnosis D D M M Y Y Y Y

- Provide up to date medical report including severity, prognosis and treatment plan.
- Indicate the percentage of the body surface area according to the Lund and Bowder body surface chart that is affected by third degree burns

L. Catch all ☐

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

If "yes", provide the supporting documentation/reports.

Has Maximum Medical Improvement (MMI) been reached? Yes ☐ No ☐

Please provide the percentage of WPI according to the AMA Guideline 6th Edition ☐☐☐ %

List the names and duration of all medication used:

M. Trauma ☐

Date of the event D D M M Y Y Y Y

Provide up to date medical report including severity, prognosis and treatment plan.

Has the insured life spent any time in the ICU? Yes ☐ No ☐

If "yes", how many hours/days has the insured life spent in the ICU? ☐☐☐☐☐

Has the insured life spent time on mechanical ventilation? Yes ☐ No ☐

If "yes:, how many hours/days has the insured life been mechanically ventilated? ☐☐☐☐☐

6: Details of the insured life's medical condition (to be completed by the medical practitioner) (continued)

N. Endocrine and metabolic diseases ☐

Date of diagnosis D D M M Y Y Y Y

Diagnosis/procedure

Provide up to date medical report including severity, prognosis and treatment plan.

Has any of the following investigations/procedures been performed?

- Any blood investigations — Yes ☐ No ☐
- Muscle/tissue biopsies — Yes ☐ No ☐
- CT Scans — Yes ☐ No ☐
- MRI Scans — Yes ☐ No ☐
- Ultrasounds — Yes ☐ No ☐
- Other procedures/investigations — Yes ☐ No ☐

List the names and duration of all medication used:

7: Declaration by medical doctor

Title Initials First name

Surname

Address

Postal code

Telephone number Fax number

Practice number

Qualifications

I certify that I have personally attended the patient and that all the previous statements are correct to the best of my knowledge.

Signed at

Signature of medical doctor **Date** D D M M Y Y Y Y

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