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Critical Illness Claim Form

KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW.

Liberty Life reserves the right to call for additional documents where necessary in order to validate the claim

- ☐ Certified copy of policyholder's identity document
- ☐ Certified copy of claimant's identity document
- ☐ Medical certificate
- ☐ Medical reports (please see below for the relevant report)
  - Cancer - histology report
  - Heart attack - ECG tracing and blood test results
  - CABG – surgery report
  - STROKE - CT/MRI SCAN
  - Major organ transplant - surgery report
  - End stage renal failure – blood test results

Policy number

LIFE ASSURED DETAILS

Surname

First name Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

E-mail address

Postal address

Postal code

CLAIMANT'S DETAILS *(Must always be policyholder, except where the policyholder is incapacitated or deceased)*

Surname

First name Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

E-mail address

Postal address

Postal code

CLAIM PAYMENT DETAILS

CLAIM PAYMENT METHOD

☐ EFT ☐ Cheque

BANK DETAILS FOR EFT PAYMENTS

(Please attach a copy of the latest bank statement – must not be older than 3 months, or confirmation of account details on the Bank's letterhead.)

Name of account holder

Name of bank

Account number

Branch name Branch code

Account type

CLAIM DETAILS

PLEASE INDICATE THE IMPAIRMENT BENEFIT YOU ARE CLAIMING FOR

☐ Cancer ☐ CABG ☐ End stage renal failure ☐ Heart attack

☐ Stroke ☐ Major organ transplant

CLAIM EVENT DETAILS

State the date of earliest symptoms of the illness D D - M M - Y Y Y Y Time

State the nature and earliest symptoms of the illness

When did you first consult a medical doctor regarding the illness?

What prescribed treatment are you currently taking?

Please provide copies of all results of investigations performed (e.g. ECG, histology/laboratory reports, MRI scan reports, etc.) in connection with the event that you are claiming for.

TREATING MEDICAL PRACTITIONERS DETAILS

Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc) consulted in connection with this illness

NAME	SPECIALTY	CONTACT DETAILS	DATE

FAMILY DOCTOR'S DETAILS

Doctor's full name

Telephone number Fax

E-mail address

CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I further understand that any misstatement or non-disclosure of information, which materially affects the assessment of this claim, will entitle liberty life to declare this claim null and void.

Claimant's name and surname

Claimant's signature Date D D - M M - Y Y Y Y

MEDICAL CERTIFICATE *(This certificate is to be completed by the attending (treating) medical practitioner at the insured's expense)*

Name of patient

Policy number

When were you first consulted for the current critical illness? D D - M M - Y Y Y Y

When were you last consulted for the current critical illness? D D - M M - Y Y Y Y

When is the next appointment scheduled for with the patient? D D - M M - Y Y Y Y

Was the patient referred to you? ☐ Yes ☐ No

Name of doctor who referred the patient

Specialty

Contact number

HISTORY OF CRITICAL ILLNESS EVENT

What is the patient's diagnosis

Date that the diagnosis was confirmed D D - M M - Y Y Y Y

What were your findings on initial consultation (signs, symptoms, investigations)?

Please detail all treatment / interventions to date

CURRENT STATUS OF CRITICAL ILLNESS EVENT

At the time of your most recent consultation, how did the life assured present (signs, symptoms, etc)

What further treatment/intervention is envisaged?

PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED

ACKNOWLEDGEMENT BY ATTENDING DOCTOR

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's full name

Registration number

Telephone number Fax

Email address

Doctor's signature

Date D D - M M - Y Y Y Y

DOCTOR'S STAMP