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Physical Impairment Claim Form

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

- ☐ Certified copy of policyholder's identity document
- ☐ Certified copy of claimant identity document
- ☐ Original medical reports
- ☐ Medical reports from medical specialists

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

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

Relationship to policyholder

CLAIM PAYMENT DETAILS *(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person. Please indicate with a (✓) the selected payment method)*

PAYMENT METHOD

☐ EFT ☐ Mobile Money ☐ 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

ADVICE INSURE INVEST

MOBILE MONEY PAYMENT DETAILS

Name of account holder

Mobile Money service provider

Mobile Money account number

CLAIM DETAILS

PLEASE INDICATE THE IMPAIRMENT BENEFIT YOU ARE CLAIMING FOR

- ☐ Loss of sight in both eyes
- ☐ Loss of sight in one eye
- ☐ Amputation of all fingers including thumb
- ☐ Loss of hearing in both ears
- ☐ Loss of hearing in one ear
- ☐ Amputation of all toes including big toe
- ☐ Loss of use of two limbs
- ☐ Loss of use of one limb
- ☐ Other forms of diplegia
- ☐ Accidental death
- ☐ Major burns
- ☐ Loss of speech
- ☐ Activities of daily living

ACTIVITIES OF DAILY LIVING *(Complete if selected above. Please note that 4 of these conditions must apply for you to submit a claim)*

Can you wash yourself?	☐ Yes	☐ No
Can you feed yourself or eat independently?	☐ Yes	☐ No
Do you have control over bowel and bladder functions?	☐ Yes	☐ No
Can you transfer yourself from bed to a chair despite assistance of a walking aid?	☐ Yes	☐ No
Can you move independently between rooms on a level surface despite assistance of a walking aid?	☐ Yes	☐ No
Can you independently put on or take off all clothes or shoes, including securing and fastening thereof?	☐ Yes	☐ No

IMPAIRMENT DETAILS

Please indicate if the impairment as a result of ☐ Disease/illness ☐ Accident/injury/trauma

IF MEDICAL CONDITION IS DUE TO AN ACCIDENT

Date of accident D D - M M - Y Y Y Y Time

Place

Provide details of how the accident occurred

What injuries did you sustain?

Was the accident reported to the police? ☐ Yes ☐ No

Name of police station

Case number

IF MEDICAL CONDITION IS DUE TO A DISEASE/ILLNESS

Nature and earliest symptoms of the condition

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

Date of earliest symptoms of the condition D D - M M - Y Y Y Y Date diagnosis confirmed D D - M M - Y Y Y Y

Prescribed treatment you are currently taking/using

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 *(Always complete this section)*

Name of patient

Policy number

Date on which the patient first became aware of the injury/condition D D - M M - Y Y Y Y

Date of last consultation for the current injury/condition D D - M M - Y Y Y Y

Date of last consultation for the current injury/condition D D - M M - Y Y Y Y

Date of next consultation scheduled 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

IF YES, PLEASE PROVIDE THE REFERRING MEDICAL PRACTITIONER'S INFORMATION BELOW:

Name

Contact number

E-mail address

HISTORY OF CRITICAL ILLNESS EVENT

What is the patient's diagnosis

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

Please give details of the nature and extent of the impairment

Is there a previous history of the same or similar medical conditions?

To what is the current injury/condition directly attributable?

Effect of the symptoms on normal activities of daily living

Current treatment and compliance

Future treatment options

Is the injury/condition permanent? Kindly provide detailed explanation

Is there any reason to believe that the claimant's illness, impairment or injury is in any way due to or arises entirely or partially from:

Unlawful alcohol consumption or misuse of drugs or narcotics ☐ Yes ☐ No

Unlawful alcohol consumption or misuse of drugs or narcotics ☐ Yes ☐ No

Non-compliance to medical treatment ☐ Yes ☐ No

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

Policyholder's full name and surname

Doctor's signature

Date D D - M M - Y Y Y Y

DOCTOR'S STAMP