Sanlam

Claim for Critical / Severe Illness

Employer/Scheme Name		Scheme Code	

Important information

- The claimant has the initial responsibility of providing medical and other documentary evidence of the illness at their own cost.
- The claimant is obliged to submit whatever medical or other information Sanlam may reasonably require.
- If there are any existing specialist reports available please forward copies with the claim documents.
- The claimant can only claim for the illnesses listed in their contract.
- **The employer must either post or e-mail the completed forms to:**

Sanlam Corporate: Group Risk Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville, 7532

E-mail address: sgrdisabilityclaims@sanlam.co.za

Forms and documents required

(Sanlam can only assess the critical / severe illness claim once all the relevant *fully* completed forms and documents have been received)

☐	**Critical / Severe Illness claim: Declaration by fund / employer** – *to be completed by employer (Page 2).*
☐	**Declaration by insured for critical / severe illness claim** – *to be completed by claimant (Pages 3 to 5).*
☐	**Questionnaire for medical practitioner / doctor: Critical / Severe Illness** *Form to be completed by claimant's treating specialist as well as the compiling of the report according to the Claim Requirements: Guidelines for Critical / Severe Illness insurance (Pages 7 to 14).*
☐	**Copy of claimant's Identity document**
☐	**Copies of all existing specialist reports as well as copies of all special and laboratory tests.** The claimant is responsible for the costs relating to this medical information.

Please note:

- Sanlam will request further medical information / documents if required.

Sanlam Corporate: Group Risk

Please return the completed form and supporting documents to:
sgrdisabilityclaims@sanlam.co.za

CRITICAL / SEVERE ILLNESS CLAIM

SECTION A: Declaration by employer (Compulsory, must be completed by the employer)

1. Particulars of the fund/scheme

Name of branch / participating employer			
Postal Address		Postal code	
E-mail address			
Telephone number			

2. Personal details of the insured

First name(s)								
Surname								
Gender								
RSA identity number*								*Compulsory
If not RSA, passport number*								*Compulsory
Passport expiry date								*(dd/mm/yyyy)*
Date of birth								*(dd/mm/yyyy)*
Marital status:	Single		Married		Divorced		Life Partner		Widowed	
Occupation								
What illness or claim event stipulated in the policy is being claimed for?								

3. Particulars of membership

Pay-sheet no. *(if any)*		
Date of entering service		*(dd/mm/yyyy)*
Date of permanent appointment		*(dd/mm/yyyy)*
Commencement date of insurance		*(dd/mm/yyyy)*

Annual pensionable remuneration of insured		Date granted *(dd/mm/yyyy)*
1. On fund / scheme anniversary before critical / severe illness incident:	**R**	
2. On date of critical / severe illness incident:	**R**	
3. One year immediately before critical / severe illness incident:	**R**	
If (2) differs from (1), state the *date* of the increase.		

Did the member / insured qualify for membership of the fund / scheme on the date of commencement of the critical / severe illness?	Yes	No

Signed by the employer on behalf of the fund/scheme

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

Signature *(on behalf of scheme / HR)*		**Signature** *(the insured's manager, supervisor or any other person who is familiar with the circumstances)*	
Designation		Designation	
Date	Place	Date	Place

CRITICAL / SEVERE ILLNESS CLAIM

SECTION B: Declaration by insured (Compulsory, must be completed by the employee)

1. Personal details of the insured

First name(s)								
Surname								
RSA identity number*								
If not RSA, passport number*			Country of issue*					*Compulsory
Passport expiry date								*Compulsory
Nationality	RSA		Other *(please state country)*					
Date of birth *(dd/mm/yyyy)*			Country of birth					
Marital status	Single		Married		Life Partner		Divorced		Widowed	
Residential address								
						Postal code		
Postal address						Postal code		
E-mail address (Work)								
E-mail address (Personal)								
Cell phone number								

2. Medical History

Details of your regular family doctor:

Initials and surname			
Address			
Contact number			
E-mail address			
Since when have they been your family doctor?			*(dd/mm/yyyy)*
Date of last consultation			*(dd/mm/yyyy)*
Who was your previous family doctor?			

3. Nature of claim and particulars of consultations

For which illness stipulated in your contract are you claiming?		
Describe the symptoms which you are experiencing and state the date the symptoms began.		
On which date did you consult a doctor regarding these symptoms for the first time?		*(dd/mm/yyyy)*
State the initials, surname and address of the doctor whom you consulted, as well as the contact number.		

Please state the details of the doctors / specialists and date of consultations regarding the condition that caused the claim:

Name and surname	Type of specialist	Address	Contact number	Date of first consultation *(dd/mm/yyyy)*

State the initials, surname, address and contact number of the doctor(s) who referred you to the specialist(s) mentioned above:

Initials and surname			
Address		Postal code	
Contact number			
Initials and surname			
Address		Postal code	
Contact number			

Is this claim as a result of an accident?	Yes		No	
Date of accident		*(dd/mm/yyyy)*		

Circumstances causing the accident:

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

Do you have critical / severe illness assurance with other companies too?	Yes		No	

If Yes, please provide the following details:

Name of insurance company			
Sum assured	**R**	Inception date *(dd/mm/yyyy)*	

Please provide any other information which, in your opinion, may influence your claim:

4. Banking details (for payment of benefits)

Please provide us with proof of the banking details from the bank

Name of account holder					
Account number				Name of bank	
Type of account	Savings		Current	Branch code	

5. Consent for Disclosure of Confidential Information and Declaration

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

with ID number _____ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess my critical / severe illness. This includes my previous medical history as well as any psychological or psychiatric records for the purposes of determining my ability to perform my 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.

Completed and signed at _____ on this _____ day of _____ 20 _____

Signature of insured _____ Signature of witness _____

Full name and surname of witness _____

Disclaimer: Party Due Diligence requirements

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

Protection of Personal Information Disclosure

Why Personal Information is required: Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:

- underwriting and providing accurate and effective insurance cover and related value-added services;
- member communication;
- market research and statistical analysis;
- verification of the personal information provided;
- to comply with all legal and regulatory requirements, including applicable codes of conduct;
- for operational and administrative processes;
- to protect Sanlam Life's interests; and
- any purposes related to the above.

Failure to provide the mandatory information will prejudice your insurance cover.

Changing and correcting Personal Information: You have the right to:

- Request a copy of your personal information as processed by Sanlam Life;
- Ask for an update and/or correction of your personal information;
- Lodge a complaint with the Information Regulator.

Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.

Other parties that may receive the Personal Information:

- We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so.
- We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.

For more information, please refer to the Sanlam Group Privacy Notice.

Sanlam

Questionnaire for medical practitioner / doctor: Critical / Severe Illness

Name of fund/scheme			
Name of claimant			
Claimant's identity number		Date of birth *(dd/mm/yyyy)*	

Dear Medical Practitioner / Doctor,

Please provide us with the information requested below. The claimant has the initial responsibility of providing medical and other documentary evidence for critical / severe illness at their own cost.

SECTION A: General information (compulsory)			
Are you the claimant's family doctor?	Yes	No	
If Yes, from which date has the claimant been your patient?		*(dd/mm/yyyy)*	
If No, please provide the family doctor's name, if known to you:			
What is the illness or claim event of the insured and details of complications, if any?			

Illness or claim event	Complications

Please give full details of previous or other abnormal physical or mental illness for which you have been consulted:

Nature of illness	Date of diagnosis *(dd/mm/yyyy)*	Date of consultation *(dd/mm/yyyy)*	Duration

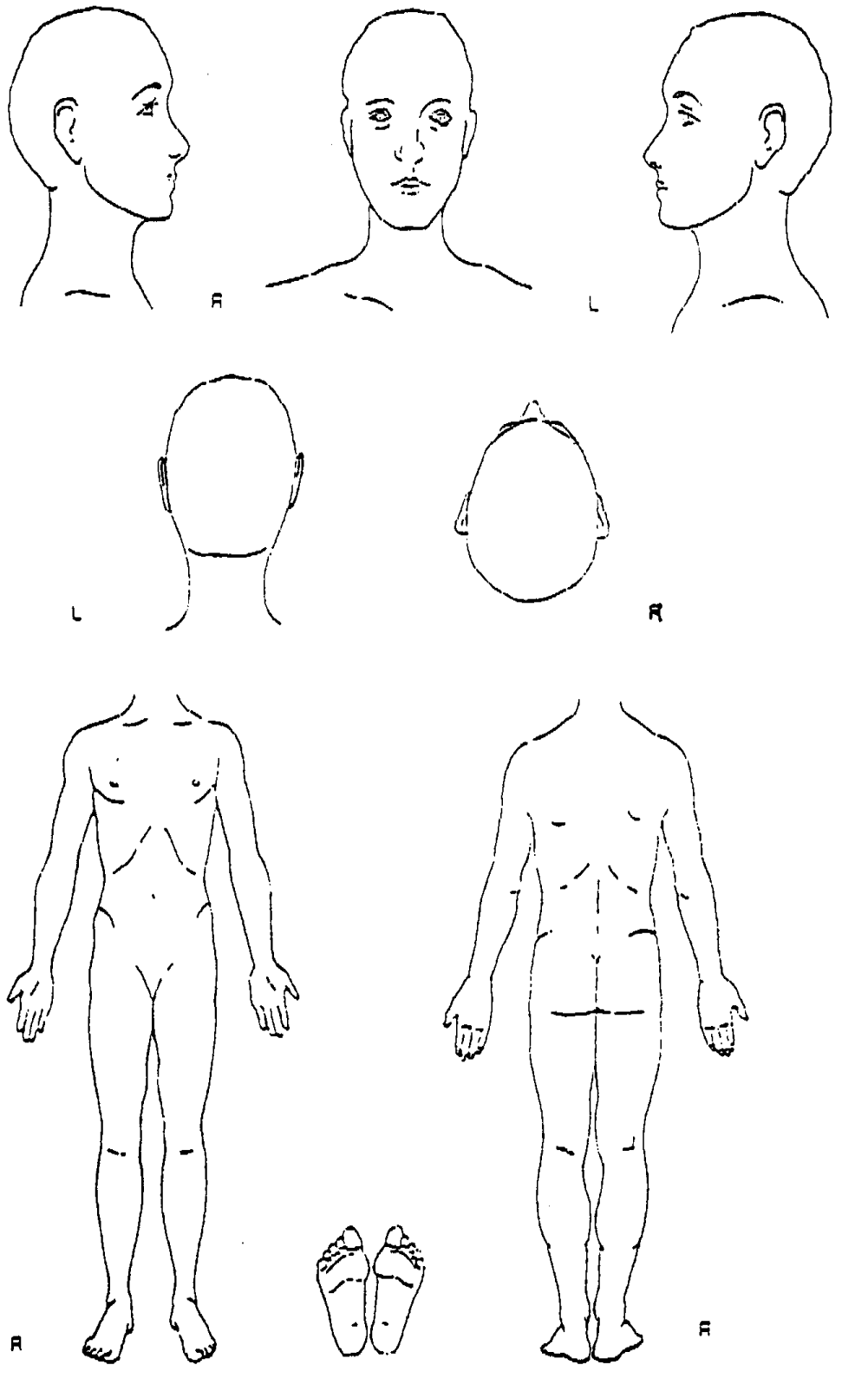
Please state the name and address of any **other** medical practitioner / doctor the claimant consulted and the contact details

Medical practitioner / Doctor	Address	Nature of illness	Contact details

Date on which illness was diagnosed / Date of the loss / Date of the incident		*(dd/mm/yyyy)*
Date of first consultation		*(dd/mm/yyyy)*

ANNEXURE E – Burns (to be completed in the case of burns)

Please indicate where the burns were sustained on the diagram below



SECTION B: Claim Requirements: Guidelines for Critical / Severe Illness insurance

Cancer and Tumours	
All Cancers (Stage I to IV) All brain tumours All benign endocrine tumours Amyloidosis	*Up to date clinical report from the treating medical specialist, *including* all of the following: 1. Latest staging of disease; 2. Pathology report(s); 3. Surgical procedures, if any were performed; 4. Treatment plan.
*Basic requirements and the following cancers will need additional requirements for consideration:	
All chronic lymphocytic leukemia's	As per above PLUS Rai Classification of disease
All lymphomas	As per above PLUS Ann Arbor Classification of disease
All myelomas	As per above PLUS Durie-Salmon scale classification
All prostate cancers	As per above PLUS Gleason scoring

Cardiovascular Conditions	
Heart attack	1. Clinical report *including* date of diagnosis, extent of infarction (transmural or sub-endocardial); 2. Copy of all ECG's available (i.e. old and new); 3. Serial Cardiac enzymes (CK, CK-MB fraction) copy of lab reports; 4. Cardiac markers (e.g. trop T); 5. Other: Reports of echocardiogram, angiogram. *If impaired ejection fraction:* 6. A repeat Echocardiogram 6 weeks later.
Coronary artery bypass graft (CABG) & angioplasty	1. Cardiologist's report; 2. Operation report.
Cardiomyopathy	Up to date cardiologist report, *including* all of the following: 1. Echocardiogram(s) with the ejection fraction; 2. Effort ECG, where possible, w.r.t. METS reached; 3. Comment on whether maximum medical improvement has been reached; 4. All other relevant report(s)
All rhythm abnormalities	1. Cardiologist's report; 2. Copies of ECG or Holter tracing reports; 3. Operation report regarding pacemaker, defibrillator or ablation.
All structural defects and structural diseases of the heart	1. Cardiologist's and/or cardiothoracic surgeon's report 2. Operation report
All vascular conditions of neck and brain	1. Specialist's detailed report including treatment and response; 2. Operation report; 3. Copies of all vascular studies done (e.g. Doppler studies, angiography, CT or MRI); *In addition (for a Stroke):* 4. Specialist Physician's assessment after maximal medical improvement

All conditions and diseases of the aorta and major vessels	1. Specialist's report (Cardiologist/Cardiothoracic Surgeon/Physician) 2. Copies of angiography and all laboratory tests must be included; 3. Operation report (where applicable).	
All peripheral conditions or diseases	1. Vascular surgeon's report; 2. Operation report (where applicable); 3. Copies of all vascular studies done (e.g. Doppler studies, angiography, CT or MRI).	
Primary pulmonary hypertension	Specialist physician's report confirming the diagnosis, *including:* 1. NYHA rating; 2. All copies of mean pulmonary artery pressures.	

Central Nervous System		
For all neurosurgical procedures	1. Neurosurgeon's report; 2. Operation report.	
For status epilepticus with neurological impairment	1. Specialist's report; 2. Copies of all EEG's; 3. Copies of all drug serum levels; 4. Detailed clinical records of 12 months or more.	
For Guillain-Barré syndrome	Detailed Specialist's report *including:* 1. All records of assisted ventilation; 2. Impairment assessment after 6 months.	
For all neurological impairments	Neurosurgeon's or neurologist's report, *including:* 1. Detailed neurological assessment of any impairments including assisted ventilation records; 2. Operation report where appropriate; 3. Copies of all radio-imaging.	
All motor diseases	1. Neurologist's detailed report; 2. Lab blood results; 3. Copies of all nerve conduction tests; 4. Radio-imaging results; 5. Assessments of ADL's.	
Coma	1. Specialists' report including neurological impairment noted; 2. Detailed clinical record of assisted ventilation including records of serial GCS screening.	
Cognitive impairment	1. Specialist's detailed report (i.e. must include copies of all testing to exclude other causes); 2. Copies of all radio-imaging; 3. Assessment of ADL's.	

Multiple sclerosis	1. Detailed reports from neurologist (with respect to diagnosis, also a confirmatory report by 2nd neurologist); 2. Particular attention to the type of neurological deficits, date of onset and its/their permanence, where relevant; 3. Radio-imaging reports.	

Connective		
Scleroderma, Polyarteritis nodosa, Wegener's or Sarcoidosis	1. Copies of all laboratory tests, biopsy finding and imaging; 2. Details of all organ involvement with documented evidence.	
Rheumatoid Arthritis	Rheumatologist report, and *must include* the following: 1. Blood tests (Rheumatoid Factor); 2. Details of joint involvement (all affected joints to be listed, all x-ray copies); 3. Detailed full treatment history and response to treatment, to date.	
Systemic lupus erythematosus (SLE)	Clinical report by rheumatologist, *including* 1. Qualifying diagnostic criteria; 2. All blood tests; 3. Organ involvement and evidence of this.	

Ears		
Hearing loss	Detailed clinical report by ENT, *including*: 1. Treatment history; 2. Copies of all audiograms and scans. *Where applicable, the following as well:* 3. Operation report 4. Acoustic reflex testing report; 5. Balance testing report.	

Gastrointestinal (Git) Disorders		
All conditions	Specialist's report, must include the following: 1. Biopsy reports; 2. Operation report or evidence of inoperable condition; 3. Treatment history. *For liver disorders, also include:* 4. Staging of disease using Child-Pugh ratings.	

Infections		
Malaria	1. Detailed specialist report noting impairment as well, to be completed 3 months after event; 2. All serology of parasite count.	
Bacterial meningitis	1. Detailed specialist report; 2. Copies of all serology and special investigations.	

Human immunodeficiency virus (HIV)	Needle-stick Injury 1. Specialist reports; 2. Copies of injury on duty notification; 3. Copies of initial HIV and follow up HIV test; 4. Copies of date of submission of informing the insurer (client directly) *Clinical manifestation of Aids:* 1. Specialist report; 2. Serial CD4 counts while on treatment; 3. Detailed treatment history; 4. Classification of disease according to World Health Organisation (WHO) staging for HIV infection.	
Loss of bowel or bladder function	1. Specialist report with detailed history of traumatic event; 2. Copies of radio-imaging.	

Injuries / Accidents		
All Burns	Specialist report with full details on degree of burn and affected body areas (according to standardised scale, e.g. Lund and Brower Chart)	
All Fractures	1. Specialist report with detailed history of traumatic event; 2. Copies of all x-rays and scans; 3. Operation report (where applicable).	
Coma, assisted ventilation	1. Specialist's report including neurological impairment noted; 2. Detailed clinical record of assisted ventilation including records of serial GCS screening.	
Spinal cord injuries	1. Specialist report with detailed history of traumatic event; 2. Copies of radio-imaging.	
Abdominal trauma	1. Specialist report with detailed history of traumatic event; 2. All operation reports	
Trauma with nerve injury	1. Specialist report including details of traumatic event; 2. Copies of all neurophysiological tests.	
Animal Bites	*Dog bites:* 1. Specialist report including details of traumatic event; 2. Copies of all neurophysiological tests. *Snakebites:* 1. Detailed clinical report by specialist; 2. Copies of all blood tests; 3. Hospital records.	
Poison	1. Detailed clinical report by specialist; 2. Copies of all blood tests; 3. Hospital records.	

Lymph and Blood		
For all blood disorders:	1. Specialist's report. 2. Detailed treatment reports: including clinical record of all blood transfusions with dates, no. of units; 3. Haematology lab results; 4. Operation reports (where applicable). *In addition, for diffuse Intravascular clotting:* 5. Scoring according to International Society on Thrombosis and Haemostasis (ISTH).	

Musculoskeletal		
For loss of use of any limb or part of limb:	1. Medical report; 2. Detailed documented evidence of degree of affected body part/ limb function. (Each limb should be assessed individually)	
For infection of long bone or joint:	1. Orthopaedic surgeon's report; 2. Copies of all x-ray or scan reports; 3. Biopsy reports and / or laboratory results of fluid analysis and culture; 4. Detailed treatment history.	
For nerve repair after complete severance	1. Surgeon's or neurosurgeon's report; 2. Operation report.	
For Paget's disease of the bone:	1. Specialists report; 2. X-ray reports; 3. Copies of all diagnostic tests performed.	

Renal Disorders		
All Diseases and vascular events of the renal system	1. Nephrologist report; 2. Lab, serology results; 3. Biopsy / radio-imaging results.	
All surgical conditions	1. Surgeon's or nephrologist's report; 2. Operation report.	
Impaired function	1. Nephrologist report; 2. Lab serology results; 3. Must include urine analysis and serial GFR measured regularly over 12 months or more; 4. Dependence on dialysis to be noted.	

Urogenital Disorders		
For all urogenital disorders Male and Female	1. Specialist's report; 2. Operation report.	

Respiratory Disorders		
All chronic respiratory diseases and respiratory impairment	1. Pulmonologist report; 2. Serial records (>3) of FEV1/; FVC or DCO.	
Interstitial lung disease	1. Pulmonologist report; 2. Radio-imaging report; 3. Biopsy results.	
Severe status asthmaticus	1. Specialists' report; 2. Detailed clinical record of assisted ventilation.	
Pulmonary embolism	1. Specialists' report; 2. Detailed clinical record of assisted ventilation. Recurrent pulmonary embolism, with associated pulmonary hypertension (mean pulmonary artery pressure) > 40mmHg: 1. Specialist report including treatment; 2. Copies of all pulmonary arterial measurements.	
All surgeries of the lung(s)	1. Specialist report; 2. Operation report.	

Vision		
Diseases of the eye	1. Ophthalmologist's report; 2. Copies of all ophthalmologic tests.	
Surgical Conditions/Trauma of the Eye	1. Detailed ophthalmologist's report; 2. Copies of all ophthalmologic tests; 3. Operation report, where applicable.	
Loss of Vision	1. Ophthalmologist's report; 2. Copies of all ophthalmologic tests including visual acuities; 3. Brain scans, where applicable.	

Catch-All		
General	Detailed medical report with full details with regards to permanent Impairment. All supporting documents to be included.	
Terminal illness	Detailed medical report with full details with regards to terminal illness. All supporting documents to be included	

Information and signature of Medical Practitioner / Doctor			
Initials and surname			
Qualifications		Practice number	
Address		Postal code	
Contact number			
Signature		Date *(dd/mm/yyyy)*	