momentum

Critical illness claim form

(Cardiac and arterial system, Cancer and Nervous system)

(To be completed by client and medical doctor)

Policy number

This form is relevant for the following claims only:

A. Cardiac and arterial system B. Cancer C. Nervous system

Please complete a *Critical illness claim form* (CLAIM015) for any other 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	**Cardiac & Arterial system**	**Cancer**	**Nervous system**
Complete the following sections on this form	1, 2, 3, 4	1, 2, 3, 4	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 complete 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.

Medical doctor	**Cardiac & Arterial system**	**Cancer**	**Nervous system**
Complete the following sections on this form	5A and 6	5B and 6	5C 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

Signature

Date D D – M M – **2 0** Y Y

Section 1: Details of insured life

Title | Initials | First name

Surname

Identity number (RSA residents only) | Permanent ID Yes ◯ No ◯

Passport number (non-RSA residents only) | Date of birth D D – M M – Y Y Y Y

Passport expiry date D D – M M – Y Y Y Y

Passport country of issue

Postal address

Postal code

Telephone - work | Telephone - home

Cellphone number

E-mail address

Section 2: Request to medical specialist, hospital or clinic

Which hospital was the insured life treated at

Treatment date D D – M M – 2 0 Y Y | File number

Doctor's name

Doctor's address

Postal code

Telephone - work

Section 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, please indicate the name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s):

Name	Address	Illness	Date	Duration

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

Name of medical aid

Member number

Name of main member

Section 4: 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.

I accept and understand that I am limiting my right to privacy. To enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits as a result of this, or any other application for insurance that I have made, or that was made for me as the insured life, I authorise Momentum, a division of MMI Group Limited, including their current and future subsidiaries and/or representatives:

- to obtain from any person, any information that Momentum requires for purposes of underwriting this application and/or claims arising from this policy. I authorise such person(s) to give the said information to Momentum, and
- to share with other insurers any information in this application or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

Signed at

Signature of insured life

Date D D – M M – **2 0** Y Y

Section 5: Details of the insured life's condition

Please 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. Cardiac and arterial system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

Please list the insured life's clinical symptoms present at the time of the event:

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

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Echocardiogram Yes ○ No ○
- Angiogram Yes ○ No ○
- Blood tests including cardiac markers Yes ○ No ○
- Doppler ultrasounds Yes ○ No ○
- CT scans or MRI scans Yes ○ No ○
- Any surgical procedure Yes ○ No ○
- ECG (Are ECG changes present)? Yes ○ No ○

If Yes, please specify:

1. Q waves Yes ○ No ○
   Which leads?
2. ST Segment Elevation Yes ○ No ○
   Which leads?
3. ST Segment Depression Yes ○ No ○
   Which leads?
4. T Wave abnormalities Yes ○ No ○
   Which leads?

Section 5: Details of the insured life's condition (continued)

A. Cardiac and arterial system (continued)

5. Complete bundle branch block — Yes ○ No ○
   Which leads? _____
6. Other — Yes ○ No ○
   Please specify? _____
7. Was PCTA or Stenting performed? — Yes ○ No ○
8. Was a CABG performed? — Yes ○ No ○
   If Yes, how many vessels? _____
9. What is the insured life's NYHA Class? Class I ○ Class II ○ Class III ○ Class IV ○
10. What is the current ejection fraction _____ %

- Other procedures/investigations (If Yes, please provide the supporting documentation/reports.) — Yes ○ No ○

B. Cancer

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure, including staging (TNM or other staging if applicable) _____

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

Has any of the following investigations/procedures been performed?

- Histopathology — Yes ○ No ○
- Chemotherapy/Radiotherapy — Yes ○ No ○
- Any surgical procedures — Yes ○ No ○
- Other procedures/investigations — Yes ○ No ○

If Yes, please provide the supporting documentation/reports.

C. Nervous system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure, including staging/grading (if appropriate) _____

Please provide up to date medical report including severity, neurological deficit, if necessary.

If Stroke, is there any neurological deficit present after 3 months? — Yes ○ No ○

If yes, please provide full details:

Has any of the following investigations/procedures been performed?

- CT scans — Yes ○ No ○
- MRI scans — Yes ○ No ○
- X rays — Yes ○ No ○
- Any blood investigations — Yes ○ No ○
- Nerve conduction studies — Yes ○ No ○
- Electromyograms — Yes ○ No ○
- Muscle biopsies — Yes ○ No ○
- CSF analysis — Yes ○ No ○
- Operation or endovascular procedures — Yes ○ No ○
- Other procedures/investigations — Yes ○ No ○

If Yes, please provide the supporting documentation/reports.

Please list the names and duration of all medication used:

Section 6: 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 – **2 0** Y Y