momentum

Critical illness claim form

(Cardiac and arterial system, Cancer and Nervous system)

(To be completed by client and medical doctor)

Policy number										

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. 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 Y Y Y Y

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

2: Request to medical specialist, hospital or clinic

Which hospital was the insured life treated at

Treatment date D D M M Y Y Y Y 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

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. Cardiac and arterial 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.

Diagnosis/procedure

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", 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?
5. Complete bundle branch block — Yes ☐ No ☐
   Which leads?

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

A. Cardiac and arterial system (continued)

6. Other — Yes ☐ No ☐

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", provide the supporting documentation/reports.) — Yes ☐ No ☐

B. Cancer ☐

Date of diagnosis D D M M Y Y Y Y

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

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", provide the supporting documentation/reports.

C. Nervous system ☐

Date of diagnosis D D M M Y Y Y Y

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

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", 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", provide the supporting documentation/reports.

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

Momentum 268 West Avenue Centurion 0157
PO Box 7400 Centurion 0046 South Africa
ShareCall 0860 66 23 45 Fax +27 12 675 3911
momentum.co.za

Momentum Metropolitan Namibia Limited
MM House 5th Floor Cnr Dr Frans Indongo & Werner List Street Windhoek
PO Box 3785 Windhoek Namibia
Tel +264 (0)61 297 3000 Fax +264 (0)61 297 3573 service@momentum.com.na