momentum

Critical illness claim form

(General)

(To be completed by client and medical doctor)

Policy number

This form is relevant for the following claims only:

A. Connective tissue diseases	B. Musculoskeletal system	C. Gastrointestinal system
D. Urinary tract	E. Respiratory system	F. ENT system
G. Visual system	H. HIV/AIDS	I. Terminal illness
J. Severe aplastic anaemia	K. Major burns	L. Catch all
M. Trauma	N. Endocrine and metabolic diseases	

Please complete a *Critical illness claim form* (CLAIM 008) for Cardiac and arterial system, Cancer or Nervous System 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

Complete the following sections on this form	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 certified copy of the e 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

Complete the following sections on this form	5 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. Connective tissue diseases

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

• Any blood investigations	Yes	No
• Muscle/tissue biopsies	Yes	No
• CT Scans	Yes	No
• MRI Scans	Yes	No
• Ultrasounds	Yes	No
• Other procedures/investigations	Yes	No

If Yes, please provide the supporting documentation/reports.

Is there any joint/organ involvement (please specify)?

Please list the names and duration of all medication used:

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

B. Musculoskeletal system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

If Yes, please provide the supporting documentation/reports.

Is there any joint/organ involvement (please specify)?

Please list the names and duration of all medication used:

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

C. Gastrointestinal system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Gastroscopic or Colonoscopic procedures Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

If Yes, please provide the supporting documentation/reports.

Has the insured life experienced any weight loss? Yes No

If Yes, please specify:

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

C. Gastrointestinal system (continued)

Please list the names and duration of all medication used:

D. Urinary tract

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds 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:

E. Respiratory system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Lung function tests Yes No
- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

If Yes, please provide the supporting documentation/reports.

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

E. Respiratory system (continued)

Please list the names and duration of all medication used:

F. ENT system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Hearing tests 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:

G. Visual system

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Visual acuity testing Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

If Yes, please provide the supporting documentation/reports.

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

G. Visual system (continued)

Please list the names and duration of all medication used:

H. HIV/AIDS

Date of diagnosis D D – M M – 2 0 Y Y

Is the insured life claiming for HIV? Yes No

Is the insured life claiming for AIDS? Yes No

If Yes, we will send you a list of reports required for us to assess the claim

I. Terminal illness

Date of diagnosis D D – M M – 2 0 Y Y

What is the cause of the Terminal illness?

- Please provide up to date medical report including diagnosis, severity, prognosis and treatment plan
- What is the current life expectancy of the life insured?
- Please supply reports of all investigations and procedures performed which are relevant to the final diagnosis

J. Severe aplastic anaemia

Date of diagnosis D D – M M – 2 0 Y Y

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

Has the life insured undergone any of the following?

- Blood transfusion Yes No
- Received marrow stimulation Yes No
- Received immunosuppressive agents Yes No
- Bone marrow transplant Yes No

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Bone marrow aspirates/trephines Yes No

If Yes, please provide the supporting documentation/reports.

Please list the names and duration of all medication used:

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

K. Major burns

Date of the event D D – M M – 2 0 Y Y

- Please provide up to date medical report including severity, prognosis and treatment plan.
- Please indicate the percentage of the body surface area according to the Lund and Bowder body surface chart that is affected by third degree burns

L. Catch all

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

If Yes, please provide the supporting documentation/reports.

Has Maximum Medical Improvement (MMI) been reached? Yes No

Please provide the percentage of WPI according to the AMA Guideline 6th Edition %

Please list the names and duration of all medication used:

M. Trauma

Date of the event D D – M M – 2 0 Y Y

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

Has the insured life spent any time in the ICU? Yes No

If Yes, how many hours/days has the insured life spent in the ICU?

Has the insured life spent time on mechanical ventilation? Yes No

If Yes, how many hours/days has the insured life been mechanically ventilated?

N. Endocrine and metabolic diseases

Date of diagnosis D D – M M – 2 0 Y Y

Diagnosis/procedure

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

Has any of the following investigations/procedures been performed?

- Any blood investigations Yes No
- Muscle/tissue biopsies Yes No
- CT Scans Yes No
- MRI Scans Yes No
- Ultrasounds Yes No
- Other procedures/investigations Yes No

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

Please list the names and duration of all medication used:

Section 6: Declaration by medical doctor

I certify that I have personally attended the patient and that all the previous statements are correct to the best of my knowledge.

Title | Initials | First name

Surname

Address

Postal code

Telephone number | Fax number

Practice number

Qualifications

Signed at

Signature of medical doctor

Date D D – M M – **2 0** Y Y

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