momentum

# Lump sum disability and functional impairment benefits

| 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**

## Requirements

In order for Momentum to process your claim, the following is required:

| **Requirements** | **Own occupation disability** | **Functional impairment** | **Activities of Daily Work** |
|---|---|---|---|
| A completed claim form | ✓ | ✓ | ✓ |
| A certified copy of your identity document | ✓ | ✓ | ✓ |
| Copies of all recent medical reports | ✓ | ✓ | ✓ |
| Official proof of discharge (if employed by employer) | ✓ | | |
| A copy of a cancelled cheque or a bank statement in the name of the policyholder | ✓ | ✓ | ✓ |
| Curator bonis appointment if the claimant is not able to handle his/her own financial affairs | ✓ | ✓ | ✓ |
| Copy of official accident report<br>Certified proof of the insured life's driving license (if applicable). | ✓ | ✓ | ✓ |
| ADL or ADW questionnaire | | ✓ | ✓ |
| Certified proof of residential address, not older than three months, reflecting the name of the claimant. | ✓ | ✓ | ✓ |

We may require additional information. You must provide us with written notice of a claim within six months of the claim event. Before we admit a claim, we reserve the right to have the insured life examined by a doctor that we have chosen.

## 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: Policyholder details

Title | Initials | First name

Surname/name of legal entity

Previous surname(s)

Contact person in case of legal entity

Gender: Male ☐ Female ☐ | Correspondence language: English ☐ Afrikaans ☐

Date of birth: D D M M Y Y Y Y | Nationality

Permanent identity number | Permanent ID: Yes ☐ No ☐

Postal address

Postal code

Telephone - home | Fax - home

Cellphone number

E-mail address

## 2: Insured life details

A. If the life insured is not the policy holder this section must be completed with the life insured's details

Title | Initials | First name

Surname

Previous surname(s)

Gender: Male ☐ Female ☐ | Correspondence language: English ☐ Afrikaans ☐

Date of birth: D D M M Y Y Y Y | Nationality

Permanent identity number | Permanent ID: Yes ☐ No ☐

Postal address

Postal code

Residential address

Postal code

Telephone - work | Fax - work

Telephone - home | Cellphone number

E-mail address

Income tax number

Income tax office

## 3: Medical aid details

Current medical aid name

Current medical aid number

Medical aid telephone number | Date of joining: D D M M Y Y Y Y

Previous medical aid name

Previous medical aid number

Name of main member

## 4: Occupational history

Provide details of your employment, including your present and/or last occupation. The exact dates (at least month and year) of the commencement and termination of your service are required.

### If employed by employer

Name of employer

Address

Postal code

Telephone number

Job title and occupation

Type of industry

Nature of work

Date of commencement D D M M Y Y Y Y

Date of termination D D M M Y Y Y Y

Reason for termination of service

### If self-employed

Company name

Address

Postal code

Telephone number

Job title and occupation

Nature of work

Date of commencement D D M M Y Y Y Y

Date of termination D D M M Y Y Y Y

Reason for termination of service

What was the last date on which you were actively able to do your work? D D M M Y Y Y Y

*(Not necessarily the date of termination of service.)*

What was your total taxable income during the twelve months before your disability, excluding income from investments? R

Give details of all other benefits which you have received or expect to receive as a result of your disability. This includes payment from any employers, insurance companies, pension or retirement annuity funds, any state assistance or income from any other source:

a. Source of benefit — Policy/Benefit number

Amount R — Starting date of payment D D M M Y Y Y Y

Regular payments or lump-sum benefit R

b. Source of benefit — Policy/Benefit number

Amount R — Starting date of payment D D M M Y Y Y Y

Regular payments or lump-sum benefit R

## 5: Medical information

### 5.1 Details for occupational disability claims

**Attach all medical reports and test results. Further requirements may be required depending on the type of benefit.**

State the nature of the injuries or illness that caused your disability:

Describe the symptoms that you are experiencing:

On which date did you first experience any symptoms? D D M M Y Y Y Y

On which date did you first consult a doctor regarding these symptoms? D D M M Y Y Y Y

## 5: Medical information (continued)

### 5.1 Details for occupational disability claims (continued)

Describe how the symptoms mentioned above have affected your ability to perform the main duties of your own occupation:

Are you still able to perform some of your occupational duties? Yes ☐ No ☐

Indicate to what extent (in percentage) you were able to perform the following, and what duties you can currently perform? The percentages must add up to a total of 100%

| Prior to disability | Percentage |
|---|---|
| Administrative duties | % |
| Manual/physical duties | % |
| Supervisory duties | % |
| Travelling by car, truck, etc. | % |
| Walking and standing | % |

| Currently | Percentage |
|---|---|
| Administrative duties | % |
| Manual/physical duties | % |
| Supervisory duties | % |
| Travelling by car, truck, etc. | % |
| Walking and standing | % |

Are you still working a full working day? Yes ☐ No ☐

List and describe the main duties you are no longer able to perform:

Are you at present able to manage your personal affairs and take care of your personal needs? Yes ☐ No ☐

If “no”, what can you not do?

What was the last date on which you were actively able to do your work (where applicable)? D D M M Y Y Y Y

*(Not necessarily the date of termination of service.)*

Date of official discharge (where applicable) D D M M Y Y Y Y

Have you been hospitalised for special examinations or treatment? Yes ☐ No ☐

If “yes”, provide details:

| Name of hospital | Date of admission | Date of discharge | Patient number |
|---|---|---|---|
| | D D M M Y Y Y Y | D D M M Y Y Y Y | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | |

## 6: General practitioner of the insured life

Confidential correspondence:

Current/most recent doctor

Surname Initials

Telephone - work

Email address

When did he/she become your regular doctor? D D M M Y Y Y Y

Name of previous general practitioner Initials

Telephone - work

Email address

### Details of other doctors, specialists and consulations

Name and surname

Type of specialist

Email address

Telephone - work

## 6: General practitioner of the insured life (continued)

Details of other doctors, specialists and consulations (continued)

| | |
|---|---|
| Name and surname | |
| Type of specialist | |
| Email address | |
| Telephone - work | |

## 7: Accident details

**Complete only if your disability has been caused by an accident.**

| | | | | | |
|---|---|---|---|---|---|
| Date of accident | D D M M Y Y Y Y | | | | |
| Place of accident | | | | | |
| Accident was caused by | Motor vehicle accident ☐ | Accident at work ☐ | Accident at home ☐ | | |
| | Shooting accident ☐ | Other ☐ | | | |

Provide a brief description of the circumstances surrounding the accident:

Provide a complete copy of the accident report, all pages back and front.

| | | | |
|---|---|---|---|
| Police station | | | |
| Case number | | | |
| Telephone number | | Fax number | |

## 8: Premiums

Please note that the premium payer remains responsible for the payment of premiums while we assess a claim.

## 9: Income Tax

In accordance to the Income Tax Act we are obligated to request a Tax Directive from SARS for Retirement annuity payments.

## 10: Payment to cessionary

In the event of a policy being ceded, provide us with the official letter from the cessionary/bank confirming the bank account details into which they wish the proceeds to be paid.

In the event of a cession being cancelled, provide us with the official cancellation letter from the appointed cessionary.

## 11: 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.

## 12: Declaration by policyholder/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

I declare that to the best of my knowledge all the information in this report is accurate and complete and that I have not withheld any information which could infuence a decision on this claim. I further acknowledge that I fully understand the contents of this declaration.

Signed at

**Signature of policyholder** **Date** D D M M Y Y Y Y

## 13: Medical Information: To be completed by the treating doctor/specialist

**The specialist, physician or general medical practitioner who attends or has last attended the claimant, must complete this section in full, in black ink and in block letters. The client must pay any costs incurred.**

How long have you known the patient professionally? From D D M M Y Y Y Y to D D M M Y Y Y Y

When were you first consulted about the patient's present medical condition? D D M M Y Y Y Y

On what date was this condition diagnosed? D D M M Y Y Y Y

Diagnosis of condition

What is the underlying cause of this condition, in your opinion?

Provide a full description of the patient's present physical/mental state:

Provide a full description of the previous and current treatment including medication prescribed, surgery, rehabilitation and counselling:

Please comment on response to the treatment*:

Are you considering any further treatment, operations, procedures or investigations? Yes ☐ No ☐

If "yes", provide full details:

Is the patient's current health status likely to change in the foreseeable future? Yes ☐ No ☐

## 13: Medical Information: To be completed by the treating doctor/specialist (continued)

Has Optimal treatment*/ Maximum Medical Improvement (MMI)** been reached? Yes ☐ No ☐

If "yes", provide full details:

* ***Reasonable optimal treatment:*** *This is the treatment that Momentum may reasonably expect the insured life to undergo according to the guidelines for the specific condition under the generally accepted medical practice at claim stage. It is expected that the insured life comply with his treatment routine.*

** ***Maximal Medical Improvement (MMI):*** *A condition or state that is well stabilised and unlikely to change substantially in the next year with or without medical treatment. There may be some change over time, but further recovery is not expected.*

Has the abuse of alcohol or drugs or any other substance (specify) contributed to or caused the present condition? Yes ☐ No ☐

If "yes", provide the dates and places of treatment:

| | | | |
|---|---|---|---|
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |

Has the patient ever been counselled for this condition? Yes ☐ No ☐

If "yes", provide the dates and places of couselling:

| | | | |
|---|---|---|---|
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |
| Date | D D M M Y Y Y Y | Place | |

Provide the names and addresses of any other doctors known to you who treated the patient for his/her present condition:

| | | | | | |
|---|---|---|---|---|---|
| Title | | Initials | | First name | |
| Surname | | | | | |
| Email address | | | | | |
| Telephone number | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Title | | Initials | | First name | |
| Surname | | | | | |
| Email address | | | | | |
| Telephone number | | | | | |

Have you previously treated the patient for any other physical or mental condition not related to the present disease/illness? Yes ☐ No ☐

If "yes", provide the dates on which the conditions started, the dates and the nature of treatment:

| | |
|---|---|
| Date | D D M M Y Y Y Y |
| Condition | |
| Treatment | |

## 14: Details of patient's disability/impairment

In your opinion, is there functional impairment due to the disease/illness or medical condition? Yes ☐ No ☐

If "yes", provide full details:

Is the patient at present, or could he/she in the foreseeable future be restricted to his/her home or confined to bed? Yes ☐ No ☐

Has the patient ever been tested for HIV? Yes ☐ No ☐

If "yes", what was the result of the test?

Provide any further comments

## 15: Declaration by doctor

Policy number

Title | Initials | First name

Surname

Physical address

Postal code

Telephone number | Fax number

Cellphone number | Practice number

Email address

I declare that to the best of my knowledge, the information in this report is accurate and complete and that I have not withheld any information which could influence a decision on this claim.

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