momentum

Lump sum disability and functional impairment benefits

Policy number

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	✓	✓	✓
ADL or ADW questionnaire		✓	✓

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 – **2 0** Y Y

Section 1: Policyholder 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

Telephone - home Fax - home

Cellphone number

E-mail address

Section 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/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

Residential address

Postal code

Telephone - work | Fax - work

Telephone - home | Cellphone number

E-mail address

Income tax number

Income tax office

Section 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

Section 4: Occupational history

Please 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

Section 4: Occupational history (continued)

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

Please 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

Section 5: Medical information

5.1 Details for occupational disability claims

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

Please 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 – **2 0** Y Y

On which date did you first consult a doctor regarding these symptoms? D D – M M – **2 0** Y Y

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 ○

Please 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	%

Section 5: Medical information (continued)

5.1 Details for occupational disability claims (continued)

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 – 2 0 Y Y

(Not necessarily the date of termination of service.)

Date of official discharge (where applicable) D D – M M – 2 0 Y Y

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

If yes, please provide details:

Name of hospital	Date of admission	Date of discharge	Patient number
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	

Section 6: General practitioner of the insured life

Confidential correspondence:

Current/most recent doctor

Surname Initials

Telephone - work

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

Name and surname

Type of specialist

Email address

Telephone - work

Section 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:

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

Police station

Case number

Telephone number Fax number

Section 8: Premiums

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

Section 9: Income Tax

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

Section 10: Payment to cessionary

In the event of a policy being ceded, please 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, please provide us with the official cancellation letter from the appointed cessionary.

Section 11: Declaration by the insured life

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 influence a decision on this claim. I further acknowledge that I fully understand the contents of this declaration. I authorise Momentum, a division of MMI Group Limited, an authorised financial services and credit provider, including the current and future subsidiaries and/or representatives:

- to obtain from any person, any information that Momentum needs for this application or the policy. I also authorise and instruct such person to give the said information to Momentum, and
- to share with other insurers any information and 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 12: Declaration by the policyholder

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 – **2 0** Y Y

Section 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?

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

Please 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, please provide full details:

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

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

If Yes, please 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 (please specify) contributed to or caused the present condition? Yes ○ No ○

If Yes, please 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, please 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

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

Please 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, please 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

Section 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, please 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?

Please provide any further comments

Section 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 – **2 0** Y Y

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