momentum

Terminal Illness claim form

Policy number

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

1. A Terminal Illness claim form (CLAIM027) fully completed by the insured life and the treating specialist.
2. Copies of investigation reports and tests which confirm the final diagnosis
3. A copy of the insured life's identity document.
4. A copy of the policyholder's identity document (if different from the insured life).
5. A copy of the policyholder's bank statement.

*Additional information may be required.

1: Details of insured life

Title | Initials | First name

Surname

Name of Institution (if the claimant is an institution)

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

Residential address

Postal code

Cellphone number

E-mail address

2: Declaration of insured life

I accept and understand the limitation of 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, the policyholder and/or the insured life authorises Momentum to:

- Obtain from any person, other insurer, medical aid, medical practitioner/institution any information that Momentum requires to underwrite this application and/or for claims arising from this policy. The policyholder/insured life authorises such person(s) to give the information to Momentum, and
- 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
- 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

3: Medical details

3.1 To be completed by the treating doctor/specialist

Medical diagnosis	
Date of diagnosis	D D M M Y Y Y Y
Presenting symptoms	
Date of first consultation for this diagnosis	D D M M Y Y Y Y
Secondary medical diagnoses affecting survival	
Past treatment	
Future treatment	

How is the patient's survival/life expectancy impacted by the primary and secondary diagnoses?

4: Doctor's details

Title		Initials		First name	
Surname					
Physical address					
				Postal code	
Postal address					
				Postal code	
Telephone number			Fax number		
Cellphone number			Practice number		
Qualifications					

I state that the answers given in this certificate are correct to the best of my knowledge and belief.

Signed at			
Signature of medical doctor		**Date**	D D M M Y Y Y Y

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