

Terminal Illness claim form

Policy number

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.

Please email or fax the claim documents to:

E-mail: riskclaims@momentum.co.za

Fax: 012 675 3947 (**International:** +27 12 675 3947) (Please quote the policy number on the fax.)

Or call us for more information:

Tel: 0860 44 11 11 (**International:** +27 12 675 3052) Our office hours are from 8:00 – 17:00.

Momentum may ask for more information or set further requirements if necessary.

1: Details of insured life

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>		
Surname	<input type="text"/>						
Name of Institution (if the claimant is an institution)	<input type="text"/>						
Identity number (RSA residents only)	<input type="text"/>	Permanent ID	Yes	No			
Passport number (non-RSA residents only)	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Residential address	<input type="text"/>					Postal code	<input type="text"/>
Cellphone number	<input type="text"/>						
E-mail address	<input type="text"/>						

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	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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3: Medical details

3.1 To be completed by the treating doctor/specialist

Medical diagnosis

Date of diagnosis

Presenting symptoms

Date of first consultation for this diagnosis

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 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