momentum

corporate

Critical Illness - employer / employee declaration

Employer and employee to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

The information requested on this declaration is required and will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Omission or distortion of information could be used as a basis for the claim being declined.

Please attach a copy of the member's payslip as at date of diagnosis. We will also require the Critical illness Confidential Medical Report with copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details								
Scheme name								
Employer name								
2. Member details								
Title		Initials						
First name/s								
Surname								
Date of birth	D D - M N	/ - Y Y Y	Υ					
RSA ID	Yes	No		ID/Passp	ort No.			
Passport country of origin								
Gender	Male	Female						
Marital status	Married	Single	Divorced	Wid	dowed			
Home language								
Telephone - work					Fax			
Telephone - home					Cell			
Email								
Residential address								
							Postal code	
Postal address								
							Postal code	
Income tax office					Income tax n	umber		
Medical aid name					Medical aid n	umber		
Date employment commenced	D D - M N	/ - Y Y Y	Υ	Date of join	ing disability scheme	D D	- M M -	YYYY
Company/employee No								
Gross annual income	R							

3. Employer details									
Contact person at company									
Designation									
Telephone						Fax			=
Email									
Company address									=
(head office)							Postal coo	le	
Company address									_
(office/branch where							Postal cod	40	
member worked)							FOSIAI COC		
4. Medical details									
Diagnosis being claimed for									
Date of diagnosis	D D - M M	- Y Y Y Y							
Date of first symptoms	D D - M M	- Y Y Y Y							
When did you see a doctor abo	out your current illnes	ss/impairment for the	first tim	e?			DD-MM	- Y Y Y	Υ
Please supply name and conta	ct details of the docto	or consulted.							
Name									
Address									
							Postal cod	le	
Tel No.							_		
Have you suffered from this illn	ess/impairment previ	ously?					Yes	No	_
If Yes, give details (e.g. date di	agnosed, treatment re	eceived, name of trea	ating do	ctor etc.).					
Have you previously received a If Yes, give details (e.g. type of							Yes	No	
Please give the name, address	and tel number of vo	our regular family doc	tor/gene	eral practitio	oner.				
Name		,							
Address									=
							Postal cod	•	_
T 1 N							1 Ostal Cou	5	
Tel No.								1	
Since when has he/she been y	our family doctor?						D D - M M	- Y Y Y	Y
When was your last consultation	on?						D D - M M	- Y Y Y	Υ
If you have changed general pr				ls of all prev	1		oners.		
Name	First consultation date	Last consultation date	Tel no		Hospita	I/Address		Patient number	
									_
									_
Please give the names and cor	ntact details of all med	dical practitioners cor	nsulted	in connection	n with v	our current illr	ness/impairment.	<u> </u>	_
Name		Hospital/address		Tel no		Condition treat		Patient number	

Medical details continued Details of any hospitalisations within the last two years. Name of hospital Admission date Discharge date Reason for admission Surgery performed 5. Banking details To whom must benefit be paid? Employer Member Name of account holder Name of bank Account number Branch no. Account type Current/cheque savings transmission 6. Supporting documents required Yes No I have attached a copy of payslip 7. Declaration by employer I declare that all the information given on this form and accompanying documents is true and correct and that no material information has been witheld. I give Momentum Corporate permission to share this information with any other party who requires this information for the purpose of assisting Momentum Corporate in the assessment and management of this claim. I declare that I have the necessary authority to complete and sign this form on behalf of the employer. Name of person completing this form Designation Telephone Email Signature of Employer

M M

Date

8. Member's declaration and consent to collect and share personal and health information

I declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim being not being approved.

Consent to collect and share personal, medical and health information

Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information Act, 2013 and Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's full privacy policy can be found on www.momentum.co.za.

I consent and give permission for:

- any health practitioner (e.g. doctor, psychiatrist, etc.), allied health practitioner (e.g. occupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person or institution that has information about my health, employment related activities and personal information, to provide this information to Momentum Corporate or any 3rd party nominated by Momentum Corporate who requires this information for the purposes of assessing and managing my claim.
- Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, with a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Momentum Corporate who may require such information for the purpose of assisting Momentum Corporate in the assessment and management of my claim or for assessing the payment of a benefit under a risk policy where I am the policyholder.
- Momentum Corporate to send correspondence regarding my claim to my employer or its appointed intermediary. This correspondence will contain personal information and will inform them of the status and outcome of my claim.
- Momentum Corporate to provide my employer or its appointed intermediary with regular claims status reports which will contain personal information. Momentum Corporate will not share any health related information in the status reports unless I have given express written consent.
- Momentum Corporate to share all medical and health related information (special personal information) with the following third parties:

- 11	nomentally corporate to share all medical and health related information (special personal information) with the following time parties.
	Employer (including employer representatives) involved with my claim
	Financial Advisers and Intermediaries appointed by my employer or myself
[Any other person/s appointed by me in writing
	All of the above
[None of the above
	entum Corporate will share medical and health related information with third parties at its discretion. I confirm that I will not hold Momentum

Мо Corporate, its emplo ees, directors or agents liable in any way and l indemnify and hold Momentum Corporate harmless for the sharing of health related information in line with this consent.

I confirm that I know and understand this consent I am providing to Momentum Corporate and that I am doing so voluntarily.

Click here to read the full consent document.

	D D - M M - 2 0 Y Y
Signature of Member	Date

- Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
 - Place your scanned signature in the signature block by following the steps outlined below.
 - Store your scanned signature as a PDF document in a safe place on your computer.
 - Select the 'comments' tab from your menu in Adobe.
 - Select the 'add stamp' icon.
 - Select custom stamps.
 - Create custom stamps.
 - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
 - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
 - Place it in the document and save the document.