momentum

Dread disease - 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.

This declaration 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. Distortion of information could be used as a basis for the claim being declined.

Please attach the following:
- Copy of payslip as at date of diagnosis
- A copy of member's ID/passport

We will also require the Dread Disease Confidential Medical Report and 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 Employee Benefits disability claims.

1. Scheme details

Scheme name:

Employer name:

2. Member details

Title | Initials

First name/s

Surname

Date of birth (D D - M M - Y Y Y Y)

RSA ID: Yes / No | ID/Passport No.

Passport country of origin

Gender: Male / Female

Marital status: Married / Single / Divorced / Widowed

Home language

Telephone - work | Fax

Telephone - home | Cell

Email

Residential address

Postal code:

Postal address

Postal code:

Income tax office | Income tax number

Medical aid name | Medical aid number

Date employment commenced (D D - M M - Y Y Y Y) | Date of joining disability scheme (D D - M M - Y Y Y Y)

Company/employee No

Salary per annum (R)

3. Employer details

Contact person at the company

Designation

Tel No. Fax

Email

Company Address
(Head office)

Postal code:

Company Address
(office/branch where member worked)

Postal code:

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 - 2 0 Y Y

When did you see a doctor about your current illness/impairment for the first time? D D - M M - 2 0 Y Y

Please supply name and contact details of the doctor consulted

Name

Address

Postal code:

Tel No.

Have you suffered from this illness/impairment previously? Yes No

If Yes, give details (eg date diagnosed, treatment received, name of treating doctor etc.)

Have you previously received any benefits from any life insurance company? Yes No

If Yes, give details (eg type of benefit, when received, name of insurer etc)

Please give the name, address and tel number of your regular family doctor/general practitioner

Name

Address

Postal code:

Tel No.

Since when has he/she been your family doctor? D D - M M - 2 0 Y Y

When was your last consultation? D D - M M - 2 0 Y Y

If you have changed general practitioners in the last two years, please give details of all previous attending practitoners

Name	First consultation date	Last consultation date	Tel no	Hospital/Address	Patient number

Please give the names and contact details of all medical practitioners consulted in connection with your current illness/impairment

Name	Speciality	Hospital/address	Tel no	Condition treated	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 (for payment of benefit)

Name of account holder

Name of bank

Account number: Branch no.:

Account type: Current/cheque savings transmission

6. Supporting documents required

I have attached a copy of ID Yes No

I have attached a copy of payslip Yes No

7. Declaration by employer

I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted. I authorise Momentum to disclose this information to any other party whose opinion is required for the assessment of the claim.

Name of person completing this form

Designation

Telephone - work

Email

Signature of Employer

D D - M M - 2 0 Y Y

Date

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

Declaration
I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal and health information
I hereby consent and authorise:

- any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner , hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to MMI Group Limited ("MMI") or any 3rd party nominated by MMI who requires this information for the purposes of assessing my claim.
- MMI to furnish 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, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by MMI who may require such information for the purpose of assisting MMI in the assessment of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- MMI to furnish my employer or its duly appointed intermediary with regular claim status reports which will contain personal information but not any health related information unless I have given my express consent for this information to be provided.

Signature of Member

D D - M M - 2 0 Y Y

Date

MMI Group Limited
Cape Town: Parc du Cap 4 Mispel Road Bellville 7530 PO Box 2212 Bellville 7535 South Africa
Pretoria: 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa
www.momentum.co.za