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CLAIM FORM – CAPITAL DISABILITY

This claim form is your personal statement of your medical condition, for which you are submitting a Disability claim. Please complete this form as comprehensively as possible and do not leave out any information relating to your current or past medical history. You will also need to fill out a detailed questionnaire about your occupation and your ability to perform your occupation. Your employer will also have to complete a similar set of questions.

Section A: Insured details

Full Name:_____

ID Number:_____

Residential Address:_____

_____

_____

Contact Number/s:_____

Email Address:_____

Medical Aid:

- Name of medical aid: _____
- Medical aid number:_____
- Date joined:_____

Family doctor/usual GP:_____

Reasons for seeing your family doctor in the past 3 years :

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RMA

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Date Consulted	Diagnosis	Treatment Received

Section B: Policy details

Policy number/s:_____

Date/s of commencement:_____

Please provide details of any other Disability policies with any other insurer:

Insurer	Policy Start Date	Have you submitted a claim?

Comment:_____

Section C: Cause of claim

Diagnosis (what you are claiming for):_____

Date diagnosed:_____

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Which doctor/s diagnosed you?_____

Please list your symptoms that led to the diagnosis above:_____

_____

_____

When did you first notice these symptoms?_____

What special tests were done to confirm the diagnosis? (please include dates done and copies of results):

_____

_____

Do you have any other medical condition/s that you may or may not be taking medication for currently?

_____

On what date where you last at work:_____

When are you likely to return to work:_____

Section D: Treatment

Please list all treatment received for this condition, including medication & dosages:

_____

What side effects of treatment are you currently experiencing?_____

_____

Planned future treatment:_____

Provide details on any rehabilitation program you have undergone or plan to undergo:

_____

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Are you using any assistive devices, for example, wheelchair or crutches: Yes_____ NO_____

If yes, how long have you been using them:_____

Dates of any hospitalization(s):

Date of hospitalization	**Diagnosis**	**Treatment received**	**Outcome**

Section E: Medical practitioners

Treating GP for this condition:_____

Treating Specialist(s) (please include specialty):_____

_____

Are you seeing any other healthcare practitioner(s) currently? (e.g. physiotherapist, homeopath, chiropractor etc. Please provide their details.):_____

_____

_____

Section F: Current functional health status

Please comment on your current ability to perform the following activities:

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Activity	Independent	Need some help	Need full assistance
Dressing			
Bathing/showering			
Going to the toilet			
Feeding yourself			
Personal grooming			
Washing your hair			
Preparing a meal			
Cleaning the house			
Driving a car (if applicable)			
Using public transport			
Climbing stairs			
Use a computer			
Manage your personal finances			
Grocery shopping			

What is your greatest difficulty at present?_____

_____

_____

How has your health improved over the past 6 to 12 months?_____

_____

_____

What needs to change to allow you to go back to work?_____

_____

_____

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Section G: Declaration

Name of claimant:_____

Signature:_____ Date:_____

- **I hereby confirm that the above information is true and accurate as supplied by myself.**
- **I have read and understand the terms and conditions of my policy.**
- **I furthermore give the Insurer consent to obtain further medical evidence or to contact my medical specialists or healthcare providers to discuss my condition in further detail.**
- **I acknowledge that all information asked for in this form is taken into account when assessing the payment of benefit. Please also remember that if you do not answer the questions fully and accurately, the benefit may not be paid.**
- **I understand that RMA Life Assurance Pty Ltd will keep my Personal Information protected as required by**
- **South African Law and will only share the information with a third party for the purposes of assessment of the claim.**