

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:

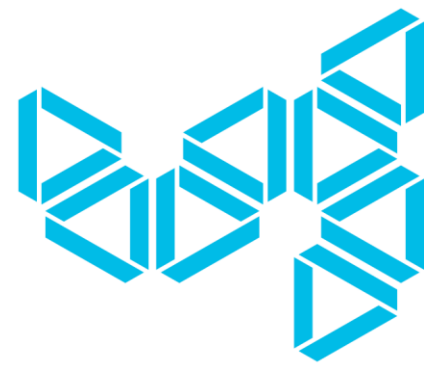
• Name of medical aid: _____

• Medical aid number: _____

• Date joined: _____

Family doctor/usual GP: _____

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



| Date Consulted | Diagnosis | Treatment Received |
|----------------|-----------|--------------------|
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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: _____

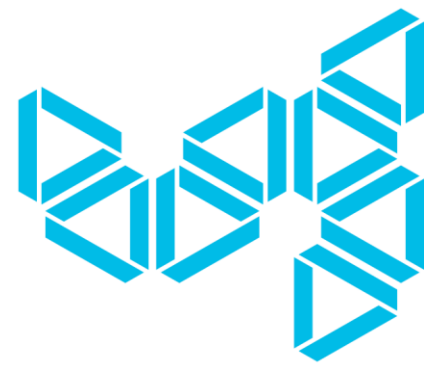
Section C: Cause of claim

Diagnosis (what you are claiming for): _____

Date diagnosed: _____



Caring | Compassionate | Compensation



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 were you last at work: _____

When are you likely to return to work: _____

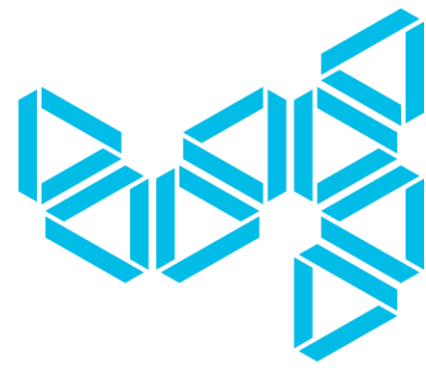
Section D: Treatment

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:



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):

| <u>Date of hospitalization</u> | <u>Diagnosis</u> | <u>Treatment received</u> | <u>Outcome</u> |
|--------------------------------|------------------|---------------------------|----------------|
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Section E: Medical practitioners

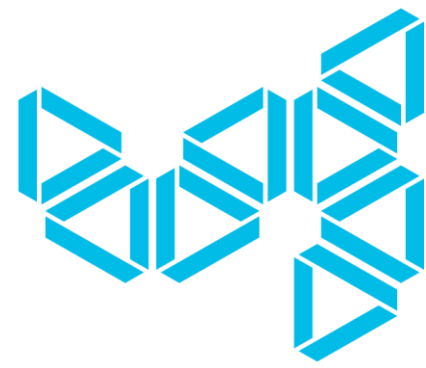
Treating GP for this condition: _____

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:



| 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 | | | |

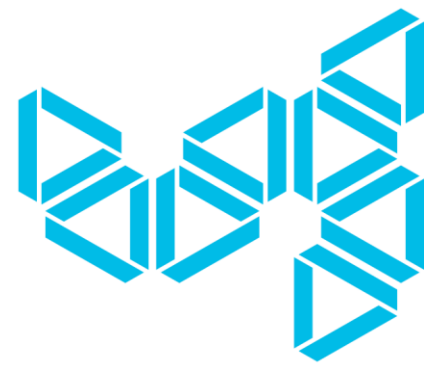
What is your greatest difficulty at present? _____

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.