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Form in support of Terminal Illness Accelerator claim on Life benefit

To be completed by the claimant

Policy holder details

Policy number: _____

Full names: _____

Surname: _____

ID number: _____

Details of the Life insured

Full names: _____

Surname: _____

Date of birth: _____

ID number: _____

Physical address: _____

_____

Postal address: _____

_____

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Email address: _____

Landline number: _____

Cell phone number: _____

Claim details

What is the diagnosis/reason for claiming:_____

When was the condition diagnosed:_____

_____

MEDICAL PRACTITIONER AND MEDICAL AID DETAILS

Name and address of the insured life's usual family doctor: _____

_____

Name and address of all doctors who have attended to the insured life during the last five years:

Date of illness/injury	Duration of illness/injury	Nature of illness/injury	Doctor or institution	Telephone No.

a) Name of insured life's medical aid society:_____

b) Medical aid membership number: _____

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Does this insured life have insurance with any other company? Please give details.

Name of Company	Insured Amount	Policy Inception Date

Supporting documentation required

The following documents must be submitted with the claim form:

1. Certified copy of insured person's ID
2. Certified copy of the beneficiary's ID
3. Completed medical report / medical claim form with supporting test results

Further information may be requested at our discretion.

DECLARATION

I ,the claimant hereby notify Rand Mutual Life of the terminal illness diagnosis of the life assured and declare that the above answers and full statements are true to the best of my knowledge and belief and that I have withheld no material fact from the company.

I declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to the patient to furnish Rand Mutual Life, or persons acting on behalf of Rand Mutual Life, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital records, including the results of all tests undergone by the patient. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

I understand that this terminal illness benefit is an accelerator to the life cover policy held and that it is approved at the discretion of Rand Mutual Life if the policy terms are met. If it is paid, it reduces the life cover by the claim value paid out.

Title:_____First names: _____

Surname: _____

RMA

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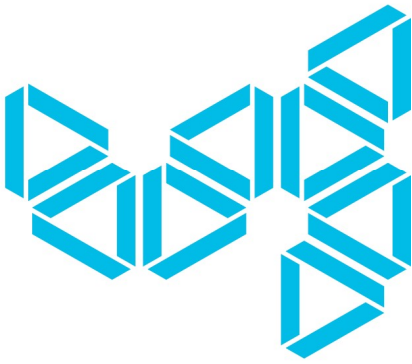

Account Holders name: _____

Name of bank: _____

Name of branch: _____

Branch code:_____ Account Number: _____

Type of Account: Current:___Savings: _____

Signature_____ Date:_____