Critical Illness Claim Form

Hollard.

(To be completed by the life insured)

1. Life assured details

Policy no. _____

Please answer all questions in full. Vague replies such as "N/A", "as before", etc. are unacceptable. Place a cross (x) in the relevant block where a YES or NO answer is required.

1.1 Full name _____

1.2 Date of birth | D | D | M | M | Y | Y | Y | Y |

1.3 ID no. _____ (proof of age will be required before any benefits are paid)

1.4 What are/were the habits regarding smoking? _____

1.5 Alcohol consumption? _____

1.6 Was the person insured at any time engaged in hazardous pursuits such as aviation, parachuting, motor racing, diving, underground mining, etc.? ☐ YES ☐ NO

If yes, please specify _____

1.7 Was the person insured engaged in any military, airforce or naval service at any time of the circumstances, that led to the claim?
☐ YES ☐ NO

If yes, please specify _____

2. Claim details

2.1. Dread disease claim in respect of: _____

2.2. Date of onset of illness or injury which led to the claim | D | D | M | M | Y | Y | Y | Y |

2.3 Duration of illness or injury

_____

2.4 Give detail of any other dread disease benefit that you have received or expect to receive or applied for as a result of your dread disease. If yes, provide details in the table below:

Source of benefit (State name of company and your reference no.)	**Type of benefit** (e.g. Insurance, lump sum)	**Amount**

2.5 Please supply the names and addresses of all doctors and specialists who attended to or prescribed for the person insured during the two years preceding the circumstances that led to the claim.

_____

_____

_____

_____

_____

_____

HOLLARD LIFE ASSURANCE COMPANY LIMITED (Reg. No.1993/001405/06) | 22 Oxford Road Parktown Johannesburg 2193 | PO Box 87428 Houghton 2014
T 011 351 5000 | **F** 011 351 5001 | **E** lifeclientservice@hollard.co.za

3. Illness of the life assured

3.1 Describe in detail the cause of the illness _____

3.2 Describe in detail the extent of the illness _____

3.3 What treatment are you undergoing? _____

3.4 Date of first treatment D D M M Y Y Y Y

3.5 Have you been hospitalised? ☐ YES ☐ NO

If yes, please specify _____

Date of admission D D M M Y Y Y Y

Date of discharge D D M M Y Y Y Y

3.6 Are you under medical care at present? ☐ YES ☐ NO

If yes, please supply the name and address of the medical practitioner _____

Name _____

Address _____

4. Declaration by life assured

The following declaration must be made by the life assured unless he/she is totally incapable of understanding or attending to it. In such event the declaration is to be made by such person holding a Power of Attorney to make the declaration on the life assured's behalf. A copy of the Power of Attorney must be attached to this form.

I, the life assured, do hereby declare that all the aforementioned answers are true, that nothing required by Hollard Life Assurance Company (hereafter referred to as the Company) to assess any liability for payment of the policy benefits has been withheld or concealed and that the I may be medically examined, if required, at the discretion of the Company.

I agree that these and all statements that I as the person insured have made or shall make to the Company in connection with this claim and on the proposal of the policy shall be the basis for the assessment of this claim.

I consent to the Company seeking medical information from any doctor or institution who at any time has attended to me or seeking information from any office to which I have at any time made a proposal for life or sickness or accidental insurance, or from my employer, or from any other person on anything relating to this claim. I authorise the giving of such information, including the results of any blood tests, and I agree that this authority shall remain in force after my death.

Where warranted by a change in the my condition I understand and agree that the Company has the right to cease any further benefit payments and recover any benefits paid for which the I was not eligible and I do further declare that if relevant to this claim I was in no way under the influence of intoxicating liquor or drugs when the accident occurred.

Signed at _____ this _____ day of _____ _____

Life assured signature _____ **Witness signature** _____

Life assured contact details

Tel. no. _____

Fax no. _____

Cell no. _____

E-mail address _____ Mandatory

Postal address _____

_____

_____

_____ Code _____