

Physical Impairment Claim Form

KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW.

- Certified copy of policyholder's identity document
- Certified copy of claimant identity document
- Original medical receipts
- Medical reports from medical specialists

Liberty Life reserves the right to call for additional documents where necessary in order to validate the claim

Policy number

LIFE ASSURED DETAILS

Surname

First name Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

E-mail address

Postal address

Postal code

CLAIMANT'S DETAILS *(Must always be policyholder, except where the policyholder is incapacitated or deceased)*

Surname

First name Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

E-mail address

Postal address

Postal code

Relationship to policyholder

CLAIM PAYMENT DETAILS *(Always complete this section for new applications, and complete for amendment if relevant. The Policyholder and Premium payer must be the same person. Please indicate with a (✓) the selected payment method)*

PAYMENT METHOD

- EFT
- Cheque

BANK DETAILS FOR EFT PAYMENTS

(Please attach a copy of the latest bank statement - must not be older than 3 months, or confirmation of account details on the Bank's letterhead.)

Name of account holder

Name of bank

Account number

Branch name Branch code

Account type

CLAIM DETAILS

PLEASE INDICATE THE IMPAIRMENT BENEFIT YOU ARE CLAIMING FOR

<input type="checkbox"/> Loss of sight in both eyes	<input type="checkbox"/> Loss of sight in one eye	<input type="checkbox"/> Amputation of all fingers including thumb	<input type="checkbox"/> Loss of hearing in both ears
<input type="checkbox"/> Loss of hearing in one ear	<input type="checkbox"/> Amputation of all toes including big toe	<input type="checkbox"/> Loss of use of two limbs	<input type="checkbox"/> Loss of use of one limb
<input type="checkbox"/> Other forms of diplegia	<input type="checkbox"/> Accidental death	<input type="checkbox"/> Major burns	<input type="checkbox"/> Loss of speech
<input type="checkbox"/> Activities of daily living			

ACTIVITIES OF DAILY LIVING (Complete if selected above. Please note that 4 of these conditions must apply for you to submit a claim)

Can you wash yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you feed yourself or eat independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have control over bowel and bladder functions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you transfer yourself from bed to a chair despite assistance of a walking aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you move independently between rooms on a level surface despite assistance of a walking aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you independently put on or take off all clothes or shoes, including securing and fastening thereof?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IMPAIRMENT DETAILS

Please indicate if the impairment as a result of Disease/illness Accident/injury/trauma

IF MEDICAL CONDITION IS DUE TO AN ACCIDENT

Date of accident: - - Time:

Place:

Provide details of how the accident occurred

What injuries did you sustain?

Was the accident reported to the police? Yes No

Name of police station:

Case number:

IF MEDICAL CONDITION IS DUE TO A DISEASE/ILLNESS

Nature and earliest symptoms of the condition

When did you first consult a medical doctor regarding the condition?

Date of earliest symptoms of the condition: - - Date diagnosis confirmed: - -

Prescribed treatment you are currently taking/using

TREATING MEDICAL PRACTITIONERS DETAILS

Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc) consulted in connection with this illness

NAME	SPECIALTY	CONTACT DETAILS	DATE

FAMILY DOCTOR'S DETAILS

Doctor's full name

Telephone number Fax

E-mail address

CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I further understand that any misstatement or non-disclosure of information, which materially affects the assessment of this claim, will entitle liberty life to declare this claim null and void.

Claimant's name and surname

Claimant's signature Date - -

MEDICAL CERTIFICATE *(Always complete this section)*

Name of patient

Policy number

Date on which the patient first became aware of the injury/condition - -

Date of last consultation for the current injury/condition - -

Date of last consultation for the current injury/condition - -

Date of next consultation scheduled with the patient - -

Was the patient referred to you? Yes No

IF YES, PLEASE PROVIDE THE REFERRING MEDICAL PRACTITIONER'S INFORMATION BELOW:

Name

Contact number

E-mail address

HISTORY OF CRITICAL ILLNESS EVENT

What is the patient's diagnosis

Date that diagnosis was confirmed - -

Please give details of the nature and extent of the impairment

Is there a previous history of the same or similar medical conditions?

To what is the current injury/condition directly attributable?

Effect of the symptoms on normal activities of daily living

Current treatment and compliance

Future treatment options

Is the injury/condition permanent? Kindly provide detailed explanation

Is there any reason to believe that the claimant's illness, impairment or injury is in any way due to or arises entirely or partially from:

- Unlawful alcohol consumption or misuse of drugs or narcotics Yes No
- Unlawful alcohol consumption or misuse of drugs or narcotics Yes No
- Non-compliance to medical treatment Yes No

PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED

ACKNOWLEDGEMENT BY ATTENDING DOCTOR

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's full name

Registration number

Telephone number Fax

Policyholder's full name and surname

Doctor's signature Date - -

DOCTOR'S STAMP