CLAIMS
Tel: 010 020 7655
Fax: 087 942 4725
Email: claims@stangenlife.co.za

DISABILITY CLAIM FORM

SECTION A: PARTICULARS OF THE INSURED

Policy Number

Surname | First Names

Title | Miss | Mrs | Mr | Dr | Prof | Initials

ID Number

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w) | Fax (w)

Telephone (h) | Fax (h)

Cell-phone | Communication Preference | Post | Fax | Email

Email Address

Date of Disability | Y | Y | Y | Y | M | M | D | D |

Detailed description of cause of disability

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Describe your symptoms and how they affect your ability to perform your occupational duties:

Have you previously suffered from the same or similar illness? Yes | No

If yes, from which date? Y Y Y Y M M D D

On what date did the symptoms of the disability, for which you are claiming for start? Y Y Y Y M M D D

From what date have you been totally disabled and unable to follow your normal occupation? Y Y Y Y M M D D

Which duties of your normal occupation are you not able to do?

What is your height? M

Weight Kg

DETAILS OF YOUR FAMILY DOCTOR

Surname

Initials

Physical Address

Postal Code

Telephone (w)

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State the names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)

A. Doctor | Address

Hospital / Clinic | Reference Number

Date Attended Y Y Y Y M M D D

B. Doctor | Address

Hospital / Clinic | Reference Number

Date Attended Y Y Y Y M M D D

C. Doctor | Address

Hospital/ Clinic | Reference Number

Date attended Y Y Y Y M M D D

Medical Aid Name | Medical Aid Number

SECTION B: ACCIDENT DETAILS

Where did the accident take place?

Date of the accident Y Y Y Y M M D D

Nature of accident:

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1 DETAILS OF WITNESS

First Name | Surname

Title: Miss | Mrs | Mr | Dr | Prof

Physical Address

Postal Code

2 DETAILS OF WITNESS

First Name | Surname

Title: Miss | Mrs | Mr | Dr | Prof

Physical Address

Postal Code

DETAILS OF POLICE STATION WHERE ACCIDENT WAS REPORTED

Name of Police Station

Physical Address

Postal Code

Telephone Number | Case Number

Full name, rank and police number of investigation officer:

Details of any legal action taken as a result of the accident:

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DETAILS OF POLICE STATION WHERE ACCIDENT WAS REPORTED

Doctor | Initial

Address

Postal Code

Telephone Number

SECTION C: EMPLOYER DETAILS

1. Name of current Employer | Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Date when you started working for your current employer? Y Y Y Y M M D D

Date when you were last actively able to do this job? Y Y Y Y M M D D

Type of Work | Position Held

Percentage of hours spent on:

Travelling % | Administration % | Supervision % | Manual Labour %

2. Name of previous Employer | Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Employment start date Y Y Y Y M M D D | to end date Y Y Y Y M M D D

Percentage of hours spent on:

Travelling % | Administration % | Supervision % | Manual Labour %

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3. Name of previous Employer | Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Employment start date Y Y Y Y M M D D to end date Y Y Y Y M M D D

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

4. Name of previous Employer | Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Employment start date Y Y Y Y M M D D to end date Y Y Y Y M M D D

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

SECTION D: BANK DETAILS OF THE INSURED

Name of Bank | Branch Name

Account Number | Branch Code

Name of Account Holder | Account Type

Signature of Account Holder _____ Date Y Y Y Y M M D D

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DECLARATION AND AUTHORISATION BY THE CLAIMANT

Policy Schedule Number

Declaration

I/ we _____ declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclose relevant information in respect of this claim may invalidate the claim. I / we acknowledge that I / we fully understand the contents of this declaration.

I / we acknowledge that I / we fully understand the contents of this declaration.

Authorisation

I / we hereby authorise King Price Life Insurance Limited or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I / we further authorise King Price Life Insurance Limited or any of its representatives to release any information regarding to this claim to any other interested parties that it deems necessary in respect of this claim.

I / we warrant that I am / we are legally entitled to the proceeds under this policy and that my / our estate(s) are solvent and have not been ceded or sequestrated.

Signed _____

On _____ day of _____ of 20_____

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SECTION F: TO BE COMPLETED BY INSURER

Policy Schedule Number _____ Policy commencement date Y Y Y Y M M D D

Date Claim received by INSURER Y Y Y Y M M D D

Details of Claims Committee Decision

_____

_____

_____

_____

_____

Name _____ Position _____

Signature _____