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

CRITICAL ILLNESS CLAIM FORM

Policy underwritten by: The Standard General Insurance Company Limited "Stangen", an authorised long-term insurer licenced in terms of the Long-Term Insurance Act, 1998. Registration Number 1948/029011/06 (Authorised FSP: No 47235)

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 (w)

Cell-phone

Email Address

Medical Aid | Medical Number

CRITICAL ILLNESS DETAILS

Based on the policy conditions and definitions of the critical illness, for which are you claiming?

Have you submitted a critical illness claim before? | Yes | No

If yes, please provide a provide details and date of claim

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

On what date did you first consult a medical practitioner in connection with your current condition? Y Y Y Y M M D D

On what date was your critical illness first diagnosed? Y Y Y Y M M D D

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

DETAILS OF THE DOCTOR WHO IS CURRENTLY TREATING YOUR CONDITION

Surname Initials

Physical Address

Postal Code

Telephone (w)

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BANK DETAILS OF CLAIMANT

Name of Bank

Branch Name

Account Number

Branch Code

Name of Account Holder

Account Type

Signature _____

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.

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Authorisation

I / we hereby authorise Stangen 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 Stangen 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_____