Stangen

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

SALARY PROTECTION 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)

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 (w)

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

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)

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

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

Stangen

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:

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

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

Stangen

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:

______

______

______

______

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

Stangen

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

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 ____ %

1. 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 ____ %

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

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 ___ %

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 ___ %

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

The Standard General Insurance Company Limited “Stangen” is an authorised long-term insurer licensed in terms of the Long-term Insurance Act, 1998.Registration Number 1948/029011/06 (Authorised FSP: No 47235).

Stangen

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

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 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________

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

SECTION F: TO BE COMPLETED BY STANGEN

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

Date Claim received by STANGEN Y Y Y Y M M D D

Details of Claims Committee Decision

Name ________ Position ________

Signature ________

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