

CRITICAL ILLNESS CLAIM FORM

To whom it may concern,

Please find below the Critical Illness Claim Form to be completed and signed. This form as well as the documents listed below, must be submitted to Stangen via email claims@stangenlife.co.za or by fax to 087 942 4725 or in person.

If in person, please deliver to:
Building A, Bryanston Corner, 18 Ealing Crescent, Bryanston, Johannesburg 2021

REQUIRED DOCUMENTS

To initiate the claim process:

The original or certified copies, signed by a commissioner of oaths, of the following:

1. The insured's ID document.
2. The medical certificate completed by the doctor who is currently treating or who has treated the insured;
and
3. Three (3) month's bank statements of the claimant stamped by the bank.

PARTICULARS OF THE INSURED

Policy Schedule Number

First Names

Surname

Title

Miss Mrs Mr Dr Prof

Initials

Gender

Female

Male

ID Number / Passport Number

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Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w)	Fax (w)
Telephone (h)	Fax (h)
Cellphone	Post Fax e-mail
E-mail address	
Medical Aid	Medical Aid Number

CRITICAL ILLNESS DETAILS

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

Have you submitted a critical illness claim before?	Yes	No
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If yes, please provide details and date of claim

	Y Y Y Y M M D D
On what date did the symptoms of the critical illness for which you are claiming for start?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
On what date did you first consult a medical practitioner in connection with your current condition?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
On what date was your critical illness first diagnosed?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

State 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	Ref. No.
	Y Y Y Y M M D D
	Date attended <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

B. Doctor	Address
Hospital / Clinic	Ref. No.
	Y Y Y Y M M D D
	Date attended <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

C. Doctor	Address
Hospital / Clinic	Ref. No.
	Y Y Y Y M M D D
	Date attended <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

DETAILS OF THE DOCTOR WHO IS CURRENTLY TREATING YOUR CONDITION

Surname	Initials
Physical Address	
Postal Code	
Telephone (w)	

BANK DETAILS OF THE INSURED

Name of Bank	Branch Name
Account Number	Branch Code
Name of Account Holder	Account Type
	Y Y Y Y M M D D
Signature of Account Holder _____	Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

DECLARATION AND AUTHORISATION BY THE INSURED**Policy Schedule Number****Declaration**

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

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

Authorisation

I hereby authorise any of Stangen's representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I further authorise any of its representatives to release any information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed _____

Signature of Claimant _____

Y Y Y Y M M D D

Date

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PERSONAL MEDICAL ATTENDANCE FORM

Patient name: _____

To whom it may concern,

We are currently processing a claim for the above named patient and have been informed that you have been one of her attending doctors. To enable us to finalise the claim we would appreciate your comments regarding inter alia the deceased's general health with special reference to list particular medical condition(s) here.

Please note that the life assured has signed the attached consent authorizing us to obtain the medical information.

We would also appreciate it if you would respond to the questions below.

When did the life assured first consult you? _____

On what date did the symptoms appear? _____

What were the reasons for and the date of the last consultation? _____

Please complete the schedule below:

Date	Reason for consultation	Diagnosis	Treatment	Result

Doctor Name: _____ **Practice Number:** _____**Address:** __________ **Signature:** _____**Phone Number:** _____ **Date:** _____