FedGroup Life

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CRITICAL ILLNESS COVER CLAIM

INSTRUCTIONS:

1. Please use one letter per block, complete with black ink and print clearly.
2. To avoid administration delays, please ensure this form is completed in full.

1. POLICY DETAILS:

Name of Group Risk Policy

Policy no G A

Name of Employer

2. YOUR CHECKLIST:

- Critical Illness Cover Claim Form
- Certified copy of the Claimant's ID (photo must be visible)
- Copies of the Claimant's last two months salary slips
- All payments are to be made into a bank account. We require proof of bank details (cancelled cheque / bank statement)
- Critical Illness Cover Claim Medical Report, together with supporting medical evidence to be completed by a treating Medical Examiner

3. EMPLOYEE DETAILS:

Title

Initials

Surname

Full Name/s

Tel no

Cell no

ID no

Email

Physical address

Code

Postal address

Code

4. DIAGNOSIS:

Diagnosis / Procedure

Date of diagnosis D D M M Y Y Y Y

Have you previously received any benefits from any other life insurance company?
If yes, please supply details:

Yes

No

Initial

5. MEDICAL EXAMINER DETAILS:

Name of Medical Examiner

Practice no

Physical address

Code

Postal address

Code

Tel no

Fax no

5. PAYMENT DETAILS:

To ensure fast payment and for your protection, payment will only be made by electronic funds transfer.

Payment will only be made to the policyholder or as instructed by the policyholder.

No payment to a third party will be allowed.

Name of account holder

Name of bank

Account no

Branch name

Branch no

Please ensure that the above information is correct. FedGroup Life will not be held responsible for any delays or other damage due to incorrect details provided. We will require proof of the account (cancelled cheque or bank statement with the account number and name of the account holder) when payment is made directly to the Claimant.

6. DECLARATION BY EMPLOYER:

I hereby declare that the Claimant qualified for benefits in terms of the FedGroup Life Group Risk Policy and that the above information is complete and correct.

I hereby warrant I have been duly authorised by the employer to sign this form on its behalf.

Name

Designation

Employer's signature (duly authorised)

D D M M Y Y Y Y

Date

7. DECLARATION BY CLAIMANT:

In my capacity as the Claimant, I declare and warrant that all statements and answers which may now or at the time be given in connection with this claim, whether in my handwriting or not, true and complete. I further understand that any incorrect statements or non-disclosure, which materially affects the assesment of this claim, will entitle FedGroup Life to declare this claim null and void.

FedGroup Life is hereby authorised to make payment as instructed above and I acknowledge that payment, by FedGroup Life of the benefits claimed shall release FedGroup Life from all liability in respect of such benefits.

Claimant's signature

D D M M Y Y Y Y

Date

On completion, please send this form to FedGroup Life

PO Box 782823
Sandton
2146

Tel: 011 305 2300
Fax: 011 305 2484
E-mail: grouprisk@fedgroup.co.za

Initial