

Income Protection Plan

The issue of this form does not constitute an admission of liability under the policy. Should this claim be approved the payment will automatically be credited to the account from which your premiums are collected, unless that account is a credit card account, in which case an alternative account number should be provided. If payment is to be credited to an alternative account, please provide the relevant details in Section 1.

Please complete Section 1 and have Section 2 completed by your usual medical attendant, i.e. the doctor you would have consulted most regularly during the last five years. Section 3 is to be completed by your employer.

Please attach a copy of your latest pay slip or, if you are self-employed, a copy of your latest tax return together with a statement from your accountant.

SECTION 1		
Policy No:		
Names and Surname of Claimant:		
Date of birth:		
Full postal address:		
Postal Code:		
Tel Code:	Tel No.:	
When did you first become aware of your complaint, illness or disease?		
If the condition is due to an accident, state the date of injury:		
Describe your injuries or the nature of your illness in detail:		
On what date did you first consult a doctor for this condition/injury?		
Is this a re-occurrence?		
If YES, please state the original inception date:		
Please supply full medical history relating to this condition/injury:		
Date:	Complaint:	Treatment/Advice Given:

SECTION 1 (continued)	
Please state the name and address of the doctor you first consulted for this condition/injury:	
Name:	
Address:	
Tel Code:	Tel No.:
Fax Code:	Fax No.:
What is the anticipated length of temporary total disablement?	
On what date are you expected to return to work?	
Or on what date did you return to work	
Please state the full name and address of your employer:	
Please state your gross monthly income at the time of this claim. This must be substantiated by a copy of your latest payslip.	
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If you are self-employed, this is to be substantiated by a copy of your latest tax return together with a statement from your accountant.	

BANKING DETAILS
Account Number:
Account Holder's name:
Name of Bank/Building Society:
Type of Account:
Branch:
Branch Code:

DECLARATION AND AUTHORISATION *by Policyholder or Legal Representative*

Policy no.:

I certify that my banking details are correct, failing which Chartis Life South Africa Limited is absolved against all direct losses, liabilities, suits, proceedings, costs, claims, demands, charges and expenses (including all legal and professional fees and disbursements) in respect thereof.

I accept that it is my responsibility to inform Chartis Life South Africa Limited of any changes in my banking details, failing which Chartis Life South Africa will accept no liability for changes which are not communicated or not communicated timeously.

I further declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to me to furnish Chartis Life South Africa Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment, and copies of all hospital records.

I agree that a Photostat copy or facsimile of this authorisation should be considered as effective and as valid as the agreement.

Signature

Date

CERTIFICATE OF USUAL MEDICAL ATTENDANT:

SECTION 2

Full names of patient:

Age:

Describe the patient's injury/illness:

When did the patient first become aware of the complaint, illness or disease?

If the condition is due to an accident, state the date of injury:

Is this a re-occurrence?

If YES, please state the original inception date:

When were you first consulted for this injury/illness?

Please supply a full medical history relating to this injury/illness:

Date	Complaint	Treatment/Advice Given

Does this illness/condition in any way relate to the following: Congenital conditions, chronic defects, mental disease or disorder, the abuse of alcohol, the influence of any drug not administered on the advice of a doctor, a self-inflicted injury, H.I.V./A.I.D.S. virus/ syndrome, and in the case of females, related to pregnancy?

If YES, please elaborate:

Are you the patient's usual medical attendant?

If NO, please state the name and address of the usual medical attendant:

Name:

Address:

Tel Code:

Tel No.:

Please state period that the patient will be unable to attend to his/her occupation:

From:

To:

Is the patient able to perform ANY part of his/her job?

If YES, please elaborate:

Is the patient confined to hospital or bed?	
If YES, please state:	
To:	From:
Is the patient confined to his/her home?	
If YES, please state:	
To:	From:
If it is unlikely that the patient will return to his/her usual occupation, please state what occupation/employment, if any, can now be performed.	
Please state any information not already mentioned, which might be relevant to the assessment of this disability claim.	

DETAILS OF MEDICAL ATTENDANT

Signature of medical attendant:

Name in block letters:

Date:

Tel Code:

Tel No.:

Postal Address:

Postal Code:

SECTION 3 - ABSENCE CERTIFICATE

To be completed by your employer.

I/We declare that according to our records:

Mr/Mrs/Miss:

Was absent from work from:

To:

Both dates inclusive:

Due to:

Signed:

Name:

Capacity:

Date:

Company Stamp: