TRIARC
(PTY) LTD 2012/011172/07 FSP 45009 - ORG 4040

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PO Box 569, Milnerton, Cape Town, 7441

Silverwood Block B, Silverwood Close,
Steenberg Office Park, Tokai, 7945

DREAD DISEASE CLAIM FORM

Please complete form in block letters.

Policy Number

Section 1 - Particulars of Claimant

Surname

Date of Birth d d - m m - y y y y

Full First Names

Contact Details

Telephone Home -

Telephone Work -

Cellphone -

Email

Section 2 - Nature of Claim and Particulars of Consultations

1. Stipulate the illness you are claiming for

2. Describe the symptoms you are experiencing and state the date the symptoms began

3. Details of Doctors, Specialists & Consultations you have had regarding the condition you are claiming for.

Name and Surname	Type of Specialist	Telephone	First Consultation

4. If this is NOT your Family Doctor, state the initials, surname, telephone number and address of this Doctor who referred you to the Specialist(s) mentioned above.

Telephone -

Section 3 - Medical History

Present Family Doctor

Telephone -

Since when have you been consulting this Doctor? d d - m m - y y y y

On what date did you last consult this Doctor? d d - m m - y y y y

Previous Family Doctor

Telephone -

Section 4 - Other Dread Disease Insurance

Dread disease insurance at other insurers

Name of Insurer	Policy Number	Sum Insured
		R
		R
		R
		R

Section 5 - Payments

Please note that the premium payments must be continued until a claim, if any, has been approved.

Bank Particulars

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead which indicates the Account Number and Account Holder's name.

Please complete one of the 2 options below:

1. Payment to the owner of the Policy

If the claim of the Life Insured is approved, Triarc can make the money available by means of an Electronic Funds Transfer (EFT) to the owner of the Policy. Please provide the following details.

Name of Bank | Name of Branch

Account Holder | Branch Code

Account Number

Type of Account: Cheque ☐ Savings ☐ Transmission ☐ Other ☐ ______

I the undersigned, hereby declare that the above information is true and correct and confirm that Triarc will not be held liable for any loss that may arise from the use of this information.

Signature of Authorised Person | Date d d - m m - y y y y

2. Proxy and/or payment to a Third Party.

If the Policy owner would prefer the claim payment to be handled/received by another person/institution, please provide us with the details below:

I, (Policy Owner) (First Names and Surname)

Hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Triarc against any and all claims in respect of, and in connection with, the payment by Triarc of the amount(s) concerned to this party. (delete which is not applicable).

(Third Party) (First Names and Surname)

Identity number:

Name of Bank | Name of Branch

Account Holder | Branch Code

Account Number

Type of Account: Cheque ☐ Savings ☐ Transmission ☐ Other ☐ ____

Signature of Authorised Person | Date d d - m m - y y y y

Section 6 - Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorise any person or Institution Person or Institution, Medical Practitioner, Medical Specialist, Hospital, Nursing Institution or Medical Authority to provide Triarc with any information that may be required regarding my health. Further, I irrevocably authorise Triarc to share with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Triarc or by the database operators.

Signature of authorised person | Date d d - m m - y y y y

Directors: A Dique • M J Truter • G J Nepgen

TRIARC is an authorised financial services provider FSP45009.
TRIARC insurance products underwritten by Guardrisk Life FSP76.
Council of Medical Scheme Number ORG 4040.