TRIARC
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FUNCTIONAL IMPAIRMENT BENEFIT

Please complete form in block letters. Policy Number

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Triarc's possession.
- It is also important that you should be aware of the implications of the non-payment/payment of this claim for your financial position, We therefore strongly recommend that at this stage that you should already contact Triarc to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail, fax or by post. If legible copies of documents are provided to us, the original documents will not be required.

Please note: A claim can only be submitted for the claim events as stipulated in the contract, on all the above-mentioned benefits.

Functional Impairment Benefits

Please supply the following documents

- A copy of your identity document
- Copies of all available medical reports, X-Rays, MRI scans and special medical tests done
- SAPS report or reports of injury sustained at work if a claim was caused by an accident on duty, as well as the result of the investigation if already finalised.
- The attached report by the treating specialist.

Section 1 - Particulars of Claimant

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

Full First Names

I.D. No. Country of Issue

Passport No. Date of Expiry d d - m m - y y y y

Title: Mr Mrs Miss Ms Other Gender: Male Female

Postal address Code:

Residential address

Code:

Contact Details

Telephone Home | Fax Home

Telephone Work | Fax Work

Cellphone | Email

Marital Status Single | Married | Divorced | Other

Section 2 - Nature of Claim and Particulars of Consultations

For what contractual listed illness, injury or deviations are you claiming.

State the date from which the illness or injury was first experienced. d d - m m - y y y y

Describe the illness or injury

State from which date the illness or injury was experienced? d d - m m - y y y y

On which date did you consult a doctor regarding these symptoms for the first time? d d - m m - y y y y

State the initials, surname, address and telephone number of this doctor.

Telephone | Fax

Section 3 - Medical History

State the initials, surname, address and telephone number of:

Present Family Doctor

Telephone

Previous Family Doctor

Telephone

Since when have you been consulting your present Family Doctor? d d - m m - y y y y

On what date did you last consult your present Family Doctor? d d - m m - y y y y

Provide the following information with regard to all other Doctors or Specialists you have consulted regarding the condition that gave rise to this claim.

Details of Doctors, Specialists and Consultations

Name and Surname	Type of Specialist	Address	Telephone	First Consultation

Particulars of injury

Date of injury d d - m m - y y y y

Place of injury d d - m m - y y y y

The injury was caused by: ☐ Motor vehicle accident ☐ Accident at home

☐ Shooting accident ☐ Other Specify _____

Give a brief description of how the accident happened

If there was an investigation into the cause of the injury or illness, provide the following information:

Name of Police Station:

Case Number:

Initials and Surname of Investigating Officer

Contact details Telephone - Fax -

Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report.

Did you suffer any physical loss? Yes ☐ No ☐

If "Yes", describe the nature of the loss you suffered

If the loss did not occur on the date of the accident, please state the date on which the loss took place.

d d - m m - y y y y

Section 4 - 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 provided

1. Payment to the owner of the Policy

If the claim of the Life Insured is approved, Triarc is able to make the money available by means of an Electronic Funds

Transfer (EFT)

Name of Branch

Branch Code

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

Or

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 5 - Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorise any 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

Minimum Format for compiling a report regarding accident/Functional impairment benefit claim

In support of a claim of the accident benefits of the Policy/Policies

On the life of born d d - m m - y y y y

Before you perform the examination, please determine the client's identity with the help of a photographic proof identity.

Indicate on the report of your findings - what type of proof of identity was given.

To consider the claim, we require a report containing the information below in respect of the specific loss/injury that the Claimant suffered. The claimant will bear the cost of the report. Triarc has the Claimant's permission to disclose the information.

Guidelines: Medical Report *(This list is a guideline only)*

1. The date of the accident.
2. The claimant's occupation.
3. The date of the physical loss.
4. Are you are the Claimant's regular Family Doctor?
   - If yes, please provide information relating to any relevant illnesses or injuries about which you were consulted and the dates of those consultations; or
   - If not, please provide the Family Doctor's name and telephone number.
5. If you are the Claimant's regular Family Doctor, have you ever been aware of excessive use of alcohol by the Claimant, and if so, please provide full details.
6. Has the Claimant ever been tested for HIV antibodies and if so, what was the result?
7. If the benefits of this claim will only be payable for the loss or loss of use of certain limbs, amputations thereof or certain other injuries/illnesses stipulated in the contract, please state the bodily loss/injury sustained and compile a Clinical Report according to the following requirements/guidelines per loss/injury. (Please provide copies of all Specialist Reports and/or X-Rays in your possession).

Vision Loss
- Vision acuity pre- and post-correction
- Visual field where applicable

Hearing Loss
- Audiogram with speech discrimination

Burns
- Indicate the areas of third degree burn wounds on attached sketch.

Coma
- The glasgow coma scale from admission to discharge
- Periods of ventilation and intravenous need to be indicated. (Specify dates)
- Medication administered during the period of the coma

Amputation
- Sketches indicating level of amputation

Paraplegia and Quadriplegia
- Diagnosis & clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)

Guidelines: Medical Report (Continued)

Penetrating gun-shot wounds and stab wounds

- Operation report

Fractures: (Ribs/Pelvis/Spine)

- Radiological reports
- Neurological impairment with spine fractures

Loss of bowel or bladder function

- Only the clinical report

Loss of function of a limb

- Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological impairment

Post -traumatic fat-embolism

- Report of ventilating/perfusion (VQ) scan

Liver and spleen rupture

- Operation report