

3. Current Medical Status

Please describe your current health problems

Please describe the functional difficulties you experience in activities of daily living

Please give us the dates, names and contact details of all doctors, specialists, hospitals or clinics you consulted about your medical condition over the past 12 months

(include hospital or clinic reference numbers)

Doctor / Specialist / Hospital

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Date		Contact Number												
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Other Information

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Doctor / Specialist / Hospital

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Y	Y	Y	Y	M	M	D	D							

Other Information

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3. Current Medical Status (Continued)

Doctor / Specialist / Hospital																																		
Date																		Contact Number																
Y	Y	Y	Y	M	M	D	D																											
Other Information																																		

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Date																		Contact Number																
Y	Y	Y	Y	M	M	D	D																											
Other Information																																		

Have you been hospitalized due to your medical condition over the past 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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If Yes, Please Supply

Name of Hospital																														
Date of Admission								Hospital Number										Date of Discharge												
Y	Y	Y	Y	M	M	D	D																							
Y	Y	Y	Y	M	M	D	D											Y	Y	Y	Y	M	M	D	D					

Please give the details of the treatment you received (medical and surgical) over the past 12 months																											

3. Current Medical Status (Continued)

In your opinion, has your condition improved, regressed or stayed the same? Please give details

4. Income Details

Are you working at the moment?

Yes

No

If Yes, please provide details of your duties, hours you work and your salary:

If No, when do you expect to return to work?

Do you do odd jobs for remuneration although not officially employed?

Yes

No

If Yes, please provide details of your duties, hours you work and your salary:

Are you involved in activities that (under normal circumstances) may generate an income?

Yes

No

If Yes, please provide details:

Have you attempted to earn an income or find alternative work?

Yes

No

If Yes, please provide details:

Are you receiving any income from another occupation or business venture?

Yes

No

If Yes, please provide details:

4. Income Details (Continued)

If you have claimed and/or expect to receive any benefit, income or pension for this period, from any other employer, insurance company, pension/provident fund or from any other source, please specify:

Source of Benefit																		
Amount							Type				Payment Date/Commencement							
R							Lump Sum	Recurring Payment			Y	Y	Y	Y	M	M	D	D

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Amount							Type				Payment Date/Commencement							
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5. Declaration

I make claim to the benefits of the above assurance contract/s and declare the following:

The answers and statements I have made are true, correct and I have withheld no material fact from Triarc. I agree the written statements and affidavits submitted in support of this claim shall constitute part of this claim. I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information for this claim. I authorise any person, possessing any information relating to income, illness or injury, to give Triarc or its representatives such information where it may be necessary for Triarc's consideration of the continuance of the disability benefits.

Signed at													

Date							
Y	Y	Y	Y	M	M	D	D

Member Name																									

Member Surname																										

Witness Name																										

Witness Surname																										

Member Signature

Witness Signature