TRIARC GROUP RISK

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# Group Risk Dread Disease Cover Benefit Claim Form - Employer/ Employee Declaration

## How to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

Please attach the following:

- Copy of payslip as at date of diagnosis
- A copy of member's ID/passport

We will also require the Dread Disease Confidential Medical Report and copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 086 235 5238 or emailed to employeebenefits@triarc.co.za or posted to PO Box 569 Milnerton, 7441.

## 1. Scheme Details

**Scheme Name**

**Policy Number**

**Postal Address**

**Code**

**Contact Person**

**Date of Birth**

Y Y Y Y M M D D

**ID Number**

**Country of Origin**

**Designation**

**Telephone Number**

**E-mail Address**

## 2. Details of Member

**Surname**

**First Names**

**Initials**

**Date of Birth**
Y Y Y Y M M D D

**ID Number**

**Country of Origin**

**Residential Address**

Code

**E-mail Address**

**Telephone Number**

**Cellphone Number**

**Company/Employee Number**

**Medical Aid Name**

**Medical Aid Number**

**Date of Employment**
Y Y Y Y M M D D

**When did the member first become eligible for membership of the plan?**

**Date of Eligibility**
Y Y Y Y M M D D

**Salary per Annum**
R

## 3. Current Medical Status

**Diagnosis being claimed for:**

**Date of Diagnosis** Y Y Y Y M M D D

**Date of first symptoms** Y Y Y Y M M D D

**When did you see a doctor about your current illness/impairment for the first time?** Y Y Y Y M M D D

**Please supply name and contact details of the Doctor consulted:**

**Name and Surname of Doctor**

**Physical Address**

**Code**

**Telephone Number**

**Have you suffered from this illness/impairment previously?** ☐ Yes ☐ No

**If Yes, please supply details (eg. Date diagnosed, treatment received, name of treating doctor, etc.):**

**Have you previously received any benefit from any life insurance company?** ☐ Yes ☐ No

**If Yes, please supply details (eg. Type of benefit, when received, name of insurer, etc.):**

**Please give name, address and telephone number of your regular family Doctor/General Practitioner**

**Name and Surname of Doctor**

**Physical Address**

**Code**

**Telephone Number**

## 3. Current Medical Status (Continued)

| Since when has he/she been you family Doctor? | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|

| When was the last consultation? | Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|---|

**If you have changed General Practitioners in the last two years, please give details of all previous attending practitioners.**

Name and Surname of Doctor

Telephone Number

Patient Number

Physical Address

Code

Date of First Consultation: Y Y Y Y M M D D

Date of Last Consultation: Y Y Y Y M M D D

Name and Surname of Doctor

Telephone Number

Patient Number

Physical Address

Code

Date of First Consultation: Y Y Y Y M M D D

Date of Last Consultation: Y Y Y Y M M D D

Name and Surname of Doctor

Telephone Number

Patient Number

Physical Address

Code

Date of First Consultation: Y Y Y Y M M D D

Date of Last Consultation: Y Y Y Y M M D D

## 3. Current Medical Status (Continued)

**Please give the names and contact details of all medical practitioners consulted in connection with you current illness/impairment.**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

## 3. Current Medical Status (Continued)

**Please give the names and contact details of all medical practitioners consulted in connection with you current illness/impairment. (Continued)**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

**Doctor / Specialist / Hospital**

**Speciality**

**Condition Treated**

**Consultation Date** Y Y Y Y M M D D

**Telephone Number**

**Physical Address**

**Code**

## 3. Current Medical Status (Continued)

**Details of any hospitalisations within the last five years.**

**Hospital**

**Reason for Admission**

**Surgery Preformed**

**Date of Admission** Y Y Y Y M M D D

**Date of Discharge** Y Y Y Y M M D D

**Hospital**

**Reason for Admission**

**Surgery Preformed**

**Date of Admission** Y Y Y Y M M D D

**Date of Discharge** Y Y Y Y M M D D

**Hospital**

**Reason for Admission**

**Surgery Preformed**

**Date of Admission** Y Y Y Y M M D D

**Date of Discharge** Y Y Y Y M M D D

**Hospital**

**Reason for Admission**

**Surgery Preformed**

**Date of Admission** Y Y Y Y M M D D

**Date of Discharge** Y Y Y Y M M D D

## 4. Banking Details (for payment of benefit)

**Payment of the Life Cover benefit - We instruct Triarc to pay the Life Cover benefit by Electronic Funds Transfer (EFT) as detailed here:**

1. To ensure fast payment and for your protection, payment will only be made by Electronic Funds Transfer
2. Payment will only be made to the policy owner or nominated beneficiary
3. No payment to a third party will be allowed
4. We will require proof of the account (cancelled cheque or bank statement with account number and name of accountholder)

Please ensure the account information is correct. Triarc will not be held responsible for delays or other damages because of incorrect details being provided. If payment is needed to more than three recipient, please supply separate banking details. No payments can be made to a non-South African bank.

**Account holder**

**Name of Bank**

**Branch Code**

**Account Type**

Current | Transmission | Savings

**Account Number**

## 5. Declaration of Employer

**I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted. I authorise Triarc to disclose this information to any other party whose opinion is required for the assessment of the claim.**

**Signed at**

**Date**

Y Y Y Y M M D D

**Signatory First Name(s) and Surname**

**Designation**

**Signature**

**Company Stamp**

## 6. Declaration of Member

**Declaration**

I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

**Consent to collect and share personal and health information**
I hereby consent and authorise:

- Any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Triarc (Pty) Ltd or any 3rd party nominated by Triarc (Pty) Ltd who requires this information for the purposes of assessing my claim.
- Triarc to furnish any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Triarc who may require such information for the purpose of assisting Triarc in the assessment of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Triarc to furnish my employer or its duly appointed intermediary with regular claim status reports which will contain personal information but not any health related information unless I have given my express consent for this information to be provided.

| Signed at | Date |
|---|---|
| | Y Y Y Y M M D D |

| Name and Surname |
|---|
| |

| Member Signature |
|---|
| |