Living Plan

Disability Claim Form

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OneSpark (Pty) Ltd is a registered financial services provider – FSP number 50594. The underwriter of this policy is Guardrisk Life Limited, a licensed insurer and registered financial services provider – FSP 76.

EMAIL COMPLETED & SIGNED DOCUMENTS TO:
claims@onespark.co.za

HONESTY DECLARATION

I declare that all information given in this claim form as well as information in any accompanying documents are true and correct.

I understand that **no benefits will be payable** for a claim if I **withhold information or if I give any false information**.

Claimant Name:

Claimant Signature:

Date:

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To be completed in block letters and black ink (or digitally) by the claimant

We pay a lump sum if the insured person has suffered total, permanent and irreversible disability or illness in the event of a successful claim. The disabilities covered under the benefit are as follows:

- Total permanent and irreversible loss of comprehension of language; or
- The permanent and irreversible loss of the ability to move both arms and legs (i.e. quadriplegia or paralysis of all four limbs); or
- The permanent and irreversible loss of the ability to move both legs (i.e. paraplegia or paralysis of the legs and lower body); or
- The loss of ability to move one side of your body (i.e. hemiplegia); or
- Total permanent and irreversible loss of vision in both eyes (with no light perception); or
- Total permanent and irreversible loss of use of both hands; or
- Total permanent and irreversible loss of use of both feet; or
- Stage IV (four) cancer.

This declaration will form the basis on which your claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Any misstatement could lead to the claim not being admitted.

Section A: Insured details

Policy number:

Full names:

Surname:

Gender: ☐ Male ☐ Female

Date of birth:

ID number:

Address:

Telephone number (home):

Cell number:

Email address:

Section B: Claim Cause

Please confirm the claim cause by marking the relevant block with an x:

Total permanent and irreversible loss of comprehension of language;	☐
The permanent and irreversible loss of the ability to move both arms and legs	☐
The permanent and irreversible loss of the ability to move both legs	☐
The permanent and irreversible loss of ability to move one side of your body	☐
Total permanent and irreversible loss of vision in both eyes	☐
Total permanent and irreversible loss of use of both hands	☐
Total permanent and irreversible loss of use of both feet	☐
Stage IV (four) cancer	☐

Is the above claim cause due to: ☐ Disease ☐ Accident

Section C: Accident Details

(Please fill this section in where the claim is as a result of an accident)

Date and time of accident causing the injury:

Was the accident reported to the police:

If the accident was reported to the Policy, please provide the:

a) Case reference number:

b) Name and Rank of Investigating Officer:

c) Name of Police Station and Contact Number:

Please provide a brief description of the accident:

If you were involved in a motor vehicle accident, please provide the accident report form.

Section D: Medical Details

Please fill in this table. This gives us more information about where you were hospitalised and what treatment you received for the injury or illness that lead to the disability that you are claiming for. This should be filled in regardless of the cause of your disability.

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Details of any surgery undergone, related to this incident:

Have you previously received any medical, chiropractic or psychological attention, treatment or medication with respect to the illness or injury described above? ☐ Yes ☐ No

If ‘Yes’, please specify

Please provide the names, addresses and phone numbers of all doctors that you have consulted during the last 5 years (compulsory):

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Section E: Details of medical practitioners and rehabilitation experts, relating to this incident.

Please complete the tables below regardless of the cause of your disability. This will give us more information about the doctors who treated you for the illness or injury that lead to this claim (in case we need to contact them).

General Practitioner or rehabilitation expert details

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Specialist details

Section F: Supporting documentation required

The following documents must be submitted with the claim form:

1. Copy of the life insured's ID document
2. Medical report completed by the doctor/s who treated the life insured supporting the permanent disability.
3. Police report if the injury is due to an accident

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4. Accident report form if the injury is due to a motor vehicle accident

Section G: Processing of Personal Information

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
4. Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent. Such Personal Information provided (voluntarily, unconditionally and specifically) will be utilised by Us or by any appointed third parties, on our behalf, and will be kept for such period as legislated according to the Applicable Laws.

You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

Section H: Declaration

I declare to the best of my knowledge that all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to OneSpark (Pty) Ltd, or persons acting on behalf of OneSpark (Pty) Ltd. I hereby authorise OneSpark (Pty) Ltd to furnish any medical information

contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to any medical practitioner or allied medical practitioner (e.g. occupational therapist, physiotherapist or psychologist) who may require such information for the purpose of assisting OneSpark (Pty) Ltd in the assessment of my claim.

Signature

Date:

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