



**PART B: PARTICULARS OF CHILD (to be completed only for Child Critical Illness Benefit)**

Name:

Surname:

National ID number / Date of birth:

<b>Biological Child</b>	<input type="checkbox"/>
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<b>Step Child</b>	<input type="checkbox"/>
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<b>Adopted Child</b>	<input type="checkbox"/>
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**PART C: PARTICULARS OF CLAIM**

1. Please state the medical condition for which you are claiming:

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2. Date of onset of symptoms:  /  /  Date of first consultation:  /  /

Date of diagnosis:  /  /

3. Provide brief details of the chronological history of the condition (from date of onset and progression up to date of diagnosis:)

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## PART C: PARTICULARS OF CLAIM

4. Please state the name(s) of the doctor(s) and allied medical practitioner(s) that attended to you in respect of this condition:

**Note:** It may be necessary for our claims area to contact them for further information.

Practitioner's surname and initials	Date of first and last consultation	Telephone number	Email Address
	<div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div> <div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div>		
	<div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div> <div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div>		
	<div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div> <div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div>		
	<div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div> <div style="display: flex; justify-content: space-between;"> <span>[D][D] / [M][M] / [Y][Y][Y][Y]</span> </div>		

5. Did the condition originate outside of South Africa? Yes  No

If yes, specify in which country: \_\_\_\_\_

## PART D: BANKING DETAILS

To be completed if Benefits are due to the policyholder.

Should you wish the benefit to be paid into a bank account other than that from which premiums are collected, please complete the details below and provide PPS with a proof of account. The accepted proof of account must be either a cancelled cheque or a bank-stamped letter on the bank's letterhead. PPS cannot accept responsibility for incorrect payment of benefits where this information has not been completed correctly.

Name of account holder:

Account type:

Account number:

Name of bank:

Branch name:

Branch code:

IBAN No.: (\*\*)

Bank's Physical address: (\*\*)

Type of Account:      Current  Savings  Cheque  Transmission

(\*\*): Required for International payments

**PART E: DECLARATION**

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may  YES  NO entail providing information regarding my current claim.

Financial Advisor's Name:

Financial Advisor's Email

**I authorise PPS Insurance to:**

- a) Access any information which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS will not be able to assess my claim for insurance.
- b) Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud. PPS is further permitted to process any such information in accordance or compatible with the purpose for which it was collected.
- c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies
- d) Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use your information for any purpose not provided for in your Policy Contract.

Signature of policyholder:

Signed at  this  day of  20