PPS PROFESSIONAL LIFE PROVIDER ™ PRODUCT (PLP) TERMINAL ILLNESS BENEFIT - DECLARATION BY MEMBER

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 (PPS Insurance) is an Authorised Financial Services Provider – License No. 1044

REQUIREMENTS

Claims in respect of the PPS Terminal Illness benefit should be submitted with the following supporting documents:

- Terminal Illness Benefit- Member form fully completed.
- Terminal Illness Benefit- Doctor form completed by the treating Medical Doctor.
- Detailed medical report and copies of all investigations performed to confirm the diagnosis.
- Submit the completed forms to claims@pps.co.za or fax to 011 644 4520

PARTICULARS OF LIFE INSURED

Surname: Initials:

National ID number : Cellular:

Medical aid name: Medical aid number:

Email address :

DETAILS OF CLAIM

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

2. Provide brief details of the chronological history (date of onset and progression up to now) of the medical condition:

3. Please state the name of current and previous medical practitioners who have treated you for this condition:

Doctor's name	Contact details and email address	Speciality	Date of last consultation

BANKING DETAILS FOR CLAIM BENEFIT VIA EFT

NOTE Only complete when payment is to be made into a bank account other than from which premiums are collected:

(Please attach a cancelled cheque or bank statement stamped by the bank).

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account: Current ☐ Savings ☐ Cheque ☐ Transmission ☐

Indemnity – Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect.

DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may entail providing information regarding my current medical condition

YES ☐ NO ☐

Financial Advisor's Name:

Financial Advisor's Email:

I certify that all the above information is true and correct and 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 Insurance will not be able to assess the 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 Insurance to also collect required personal information from other insurers as exchange of information helps to waive costs and combat fraud. PPS can further 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 Insurance. PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS Insurance 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