PPS Critical Illness Product Pregnancy Complications Cover Member Claim form

PPS contact details:

Claim submissions:
E: claims@pps.co.za

Claim-related enquiries:
E: memberservices@pps.co.za
T: 0860 123 777 or +27 (0)10 085 3820
Monday to Friday from 07:00 to 19:00 and Saturday from 08:00 to 13:00

Claim requirements:

Claims for these benefits must be made using the prescribed PPS claim forms, namely:

- **PPS Critical Illness Cover (CIC) – Pregnancy Complications Cover Member Claim Form**
- **PPS Critical Illness Cover (CIC) – Pregnancy Complications Cover Doctor Claim Form**
- Detailed **medical report**, this will include copies of all **relevant medical, blood and special investigations** undertaken, PLUS any other relevant documentation, to confirm the diagnosis. **A guideline for the details required** is provided for easy reference **at the bottom of the doctor's claim form**. All medical information will be treated according to the ASISA guidelines on Confidentiality of Medical Information.
- Any **costs incurred in obtaining the supporting document(s)** will be for **your account.**

PART A: PARTICULARS OF POLICYHOLDER

Member number:

ID/Passport number (if no ID):

Surname: Initials:

Cellular:

E-mail:

Medical aid name: Medical aid number:

PART B: MEDICAL CONDITION

Assessment of the Critical Illness Pregnancy complications cover will be based only on specific criteria for the conditions listed below. The list of claim definitions, which also explains the different severity levels, is attached to your latest Policy Summary and is set out in Appendix B of your PPS Provider™ Policy wording, should you wish to refer to it.

Abortion due to amniocentesis	☐	Hyperemesis gravidarum	☐
Amniotic fluid embolism	☐	Pulmonary embolism	☐
Abruption placentae	☐	Severe pre-eclampsia and eclampsia	☐
Ectopic pregnancy	☐	Sheehan's syndrome	☐
Hydatidiform mole	☐	Uterine rupture	☐

Date of diagnosis: D D M M Y Y Y Y Date of onset of symptoms: D D M M Y Y Y Y

Date of first consultation: D D M M Y Y Y Y

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	**Telephone**	**E-mail**	**Date of first consultation**	**Date of last consultation**

Is further treatment for this condition planned? Please give details:

PART C: BANKING DETAILS

NOTE: Financial governance requires that all benefits regarding Sickness claims must be settled to the same account from which your premiums are paid **(premium-paying account)**. Please note that this is an improved security measure to mitigate financial risks for claiming policyholders.

Please provide alternative bank details below if you cannot receive payment to your premium-paying account for any reason. Changing the account to which claim benefits are paid will require additional diligence and proof. **The required additional diligence will take an additional five working days before payment can be made.**

If you must change your banking details, please include the required proof together with this claim form.

I understand this note and request PPS to: *(Select the appropriate option)*

1. Pay any benefits due to my existing premium-paying account. ☐
2. Use the new account details below to pay any benefits due to me. ☐

   2.1. Please update my premium-paying account to the new details below for future premium payments. YES ☐ NO ☐

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account:

If you have selected option 2 above, please provide PPS with proof of account and certified proof of the account holder's identity. The accepted proof of account is a bank-stamped verification letter on the bank's letterhead not older than three months. PPS cannot make changes to this account without the required proof.

For payments into an international bank account:

IBAN no:

Bank's physical address:

Foreign bank accounts: *Please note that in terms of the PPS Provider™ Policy, premiums from the policyholder should be paid from a South African bank account and benefits to the policyholder should also be paid into a South African bank account, in South African currency. Accordingly, PPS Insurance assumes no responsibility or liability whatsoever in the event the policyholder pays premiums from a foreign bank account, or the policyholder nominates a foreign bank account for receipt of policy benefits. To ensure compliance with South African foreign exchange regulations, policyholders are encouraged to nominate a verified local bank account. Payment into foreign accounts may be declined or delayed pending legal clearance. Policyholders must confirm banking arrangements with PPS prior to submission. Furthermore, any payment to and from PPS Insurance involving a foreign bank shall be at the sole discretion of PPS Insurance and subject to the South African foreign exchange regulations and other relevant legislation as amended from time to time. PPS Insurance assumes no responsibility or liability to inform the policyholder of any changes in such regulations and legislation.*

Indemnity: Please take note that PPS will not be held liable for incorrect payments if the account information supplied is incorrect. By signing this document, the policyholder indemnifies PPS and holds PPS harmless against any losses, liabilities, claims, charges, expenses, costs or any other actions or demands of whatever nature, which could or might be suffered or incurred by the policyholder or any third party whether directly or indirectly, caused by and/or arising out of the payment into the above account.

PART D: AUTHORISATION TO COMMUNICATE WITH FINANCIAL ADVISER

I specifically authorise PPS Insurance to communicate any requirements to my financial adviser which may entail providing information regarding my current medical condition. YES ☐ NO ☐

Financial adviser's name:

Financial adviser's e-mail:

PART E: DECLARATION

The Professional Provident Society (PPS) Holdings Trust No IT 312/2011 is a Registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 is a licensed insurer conducting life insurance business, a licensed controlling company and an authorised financial services provider. Any reference to PPS in this form means PPS Insurance.

I _____ (member full name and surname) and ID number: _____

authorise PPS Insurance to:

a) Access any information deemed necessary to assess any insurance risk or to consider a claim. I understand that if I choose not to provide this information, PPS will not be able to assess the claim for insurance.

b) Share with other insurers and their representative 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 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, PPS Insurance's subsidiaries and affiliates 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 my 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 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 and this Part E.

Signed at _____ this _____ day of _____ 20 ____

Signature of policyholder: _____

DISCLAIMER:

By submitting this form electronically, you acknowledge that your electronic signature holds the same legal weight as a handwritten signature. For authorised electronic signature details, contact your financial adviser or e-mail memberservices@pps.co.za. You accept responsibility for the legitimacy of the submitted electronic signature. PPS will rely on technical audit trails and platform controls to determine responsibility in the event of a signature dispute.

Procedure for claiming

GENERAL

The assessment of claims for benefits is subject to PPS claim procedures and protocols. These are in place to ensure that claims are processed in a timeous manner. Please ensure that the claim form is completed in full, detailing all the required information. Omitting information may cause a delay in the finalisation of your claim. Submit the completed claim form together with all relevant documentation.

To finalise the claim, additional information (at PPS's cost) may be requested from either you or your medical practitioner. You and/or the medical practitioner will be notified if additional information is required.

To ensure a comprehensive assessment, the claim may be referred to internal and/or external medical specialists. Such a referral may take up to seven working days. You will be notified regularly of the progress of the assessment of your claim. Any delays, exceeding the seven working days, will be communicated.