FAMILY RESPONSIBILITY RIDER BENEFIT – TERMINAL ILLNESS BENEFIT FORM (CHILD) (TO BE COMPLETED BY PPS MEMBER)

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)11 644 4300
Monday to Friday from 07:00 to 19:00 and Saturday from 08:00 to 13:00

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: D D M M Y Y Y Y

E-mail:

Cell phone:

PART B: DETAILS OF THE CLAIM

Particulars of child:

Name:

Surname:

ID/Passport number (if no ID):

Biological child: Step child: Adopted child:

NOTE Refer to the bottom of the form for a list of required supporting documents.

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(s) of the doctor(s) and allied medical practitioner(s) that attended to your child, in respect of this current illness.

It may be necessary for our claims area to contact the below doctors for further information.*

Practitioner's surname and initials	First consultation date	Last consultation date	Tel	E-mail

** Please refer to Declaration*

4. Provide details of the hospital admission:

First admission

Name of hospital:

Date admitted: D D M M Y Y Y Y Date discharged: D D M M Y Y Y Y

Second admission

Name of hospital:

Date admitted: D D M M Y Y Y Y Date discharged: D D M M Y Y Y Y

PART C: BANKING DETAILS FOR CLAIM BENEFIT VIA EFT

NOTE Financial governance requires that all benefits regarding member 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.

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. 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 note that PPS will not be held liable for incorrect payments if the account information supplied is incorrect. By signing this form, 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

I/we _____ (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/we understand that if I/we 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/our 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/ourselves. PPS Insurance may be required to disclose my/our information to regulatory or government agencies.

d) Obtain credit information from any person or institution.

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

AND
I/we 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 and in this Part E.

Signature of policyholder: _____

Signature of spouse or child over 18 years of age: _____

Signed at _____ on this _____ day of _____ 20 _____

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 PPS-accredited financial adviser or e-mail memberservices@pps.co.za. Using unauthorised electronic signatures is at your own risk and PPS Insurance disclaims liability for any related issues.

PROCEDURE FOR CLAIMING FAMILY RESPONSIBILITY RIDER BENEFITS

To enable the timely assessment of the claim all required details should be fully completed. Should information be omitted there may be a delay in the finalisation of the claim.

Additional information (at PPS's cost) may be requested from either the policyholder or any medical practitioner to finalise the claim. The policyholder and/or the medical practitioner will be notified if additional information is required.

In addition to the medical information listed above, claims in respect of the Family Responsibility Rider benefit should be submitted with the following supporting documents:

Claim for biological child
Copy of unabridged birth certificate
Proof of hospitalisation (Admission and discharge dates/ICD 10 codes/patient name and surname)

Claim for stepchild
Copy of unabridged birth certificate
Copy of marriage certificate
Proof of hospitalisation (Admission and discharge dates/ICD 10 codes/patient name and surname)

Claim for adopted child
Copy of birth certificate
Proof of hospitalisation (Admission and discharge dates/ICD 10 codes/patient name and surname)
Adoption order

NOTE If your benefit stared on or after 1 April 2017 and you had similar cover at another company, kindly provide us with a copy of your membership certificate reflecting the date of inception, the date of cancellation and details of any waiting periods where applicable.