RCS
BNP PARIBAS GROUP

PERMANENT DISABILITY
CLAIM FORM

ACCOUNT HOLDER INFORMATION

Surname

First name

ID number of insured

Card account number(s)

Personal Loan account number(s)

CLAIMANT INFORMATION

Name of claimant

ID number

Postal address

Postal code

Telephone numbers

Home

Work

Cell

Fax

Email address

DECLARATION:

I hereby certifiy that the above details are true and correct.

Signature

D D M M Y Y Y Y

Date

IMPORTANT: DOCUMENTS REQUIRED TO BE ATTACHED TO THIS CLAIM FORM

- ☐ Certified boarding letter
- ☐ Certified ID of insured
- ☐ Declaration by claimant (Pg 2 & Pg 3)
- ☐ Certificate by medical practitioner (Pg 4 & Pg 5)
- ☐ Certificate by employer (Pg 6 & Pg 7)

PremDis. June 17

RCS Building, Golf Park 6, Raapenberg Road, Mowbray, 7700
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Tel: 0861 729 727
Fax: +27 (0)21 597 4733

www.rcs.co.za

Directors: RF Adams* V Berthout### BPS Cavalier# CP de Wit* *Executive / #Non-Executive / ###Alternate
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DECLARATION BY CLAIMANT

TO BE COMPLETED BY CLAIMANT

1. PERSONAL PARTICULARS

a) What is your present occupation?

b) How long have you been in this occupation?

2. NATURE OF DISABILITY

a) What is the nature of your illness or disability?

b) How was it caused?

c) On what date did you first become aware of this disability? D D M M Y Y Y Y

d) On what date did the symptoms first appear? D D M M Y Y Y Y

3. DEGREE OF DISABILITY

3.1 a) Does your disability enable/allow you to follow your own or a similar occupation? Y N

b) If no, please explain why

3.2 a) Does your disability enable/allow you to follow any occupation whatsoever? Y N

b) If no, please explain why

3.3 a) Has your health improved/remained unchanged/deteriorated over the past twelve months?

b) If deteriorated or improved, state to what extent

3.4 a) Have you been employed during the past twelve months? Y N

b) If yes: (i) dates worked

(ii) type of work

(iii) name of employer

4. PARTICULARS OF DOCTORS AND HOSPITALS

a) Give the name and address of your regular doctor

b) Since when has he/she been your regular doctor?

c) Give the names and addresses of the doctors, hospitals or clinics where you have received treatment for your illness or disability

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DECLARATION BY CLAIMANT

5.1 Details of other disability benefits

a) Are you insured against disablement with any other insurance company, fund or statutory body? Y N

b) Have you or are you expecting to receive a lump sum payment as a result of your disablement? Y N

c) Are you at present receiving periodic payments or expecting to receive such payments? Y N

5.2 If the answer to 5.1 (a), (b) or (c) above is "YES", give the following details

a) Source of benefit

b) Date of commencement D D M M Y Y Y Y (c) Amount

I, the claimant, do hereby warrant the above information as the truth. I authorise any hospital, clinic, doctor, or other individual to furnish RCS with any information in respect of the claim, including any copies of medical records, consultations, medical history, sickness or injuries the insured may have had with any institution. I have not witheld any information which could be material to the assessment of the claim.

Signed at D D M M Y Y Y Y

Commissioner of Oaths/Justice of Peace

Signature of claimant

Address

Telephone

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CERTIFICATE BY MEDICAL PRACTITIONER

TO BE COMPLETED BY MEDICAL PRACTITIONER

PATIENT'S DETAILS

1 a) Full name and surname of patient

b) Identity number of patient

c) Date of disability D D M M Y Y Y Y

d) Are you the patient's regular doctor? Y N

e) If not, state the name of the regular doctor

f) If "yes", since what date D D M M Y Y Y Y

g) Date of last consultation D D M M Y Y Y Y

2 a) What is the direct cause of the disability?

b) When was this condition first diagnosed? D D M M Y Y Y Y

c) Was the patient informed of the diagnosis? Y N

d) If possible, please state the date on which the patient first became aware of the diagnosis D D M M Y Y Y Y

3 a) Are you aware of any sickness or habit which might have given rise to the present ailment? (Please state the name of the doctor, hospital or clinic, the illness and the dates of diagnosis, if possible)

b) What contributing factors led to the disability? please provide dates of diagnosis

c) Please list consultations during the past five years (give particulars and dates)

d) Name and address of specialist(s), if patient was referred, and the date of the refferal

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CERTIFICATE BY MEDICAL PRACTITIONER

TO BE COMPLETED BY MEDICAL PRACTITIONER

PROGNOSIS

4. Please state the functional impairments caused by this condition

5. List the treatment and the response to the treatment

6. What is your opinion on the permanency of the condition?

7. If not already covered under question 4, 5, 6 what is the prognosis of this case?

(Please furnish details of all consultations by yourself or other doctors or persons in connection with illnesses, habits, tendencies or events from the first consultation to date

D D M M Y Y Y Y to D D M M Y Y Y Y

which may relate to or have led to the disability of the insured.)

(i.e. prescription of medicines, surgery, physiotherapy, psychotherapy, radiotherapy, hospitalisation, medical advice, regular medical examinations for follow-up purposes, etc.)

CONSULTATION DATE	DIAGNOSIS	TREATMENT AND MEDICATION PRESCRIBED	PROGNOSIS

Signed at D D M M Y Y Y Y

Telephone number

Signature of medical practitioner

Qualifications

MP number

Surname and initials of medical practitioner

Practising Address

PRACTICE STAMP

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CERTIFICATE BY EMPLOYER

TO BE COMPLETED BY EMPLOYER

1. PARTICULARS OF CLAIMANT/EMPLOYEE

a) Full name of employee

b) ID number

c) Current occupation

d) Period of employment From D D M M Y Y Y Y

To D D M M Y Y Y Y

e) Employee payroll number

2. EXTRACT FROM SICK RECORD

DATE FROM	DATE TO	REASON	NAME OF HOSPITAL CLINIC/DOCTOR	ADDRESS OF HOSPITAL CLINIC/DOCTOR

Name of employee's medical aid scheme & number

3. DETAILS OF DISABILITY

3.1 If the insured/employee is no longer in your employment

a) Was the insured medically boarded? Y N

b) If yes, what was the date of boarding? D D M M Y Y Y Y

c) Please provide, the medical reason(s) for boarding

d) Occupation before disability

e) Does the insured qualify for disability pension? Y N

f) If yes, what is the amount of the monthly pension?

g) Was the insured at work until retirement date? Y N

h) If not, the reason

i) Date last worked D D M M Y Y Y Y

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CERTIFICATE BY EMPLOYER

TO BE COMPLETED BY EMPLOYER

3.2 Is the insured still in your employment? Y | N

a) If yes, present occupation

b) Occupation before ill-health or disability?

c) Date last actively at work D D M M Y Y Y Y

EMPLOYER

Signed at D D M M Y Y Y Y

Signature of authorised official

Name

Employer name

Address

Email

Telephone

OFFICIAL STAMP

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