



10 Muswell Road South, Bryanston  
 PO Box 67335, Bryanston, 2021  
 Tel: 086 000 2156  
 Fax: 086 676 2565

Reg. No 1999/012567/06  
 FSP Licence No 1856

## CLAIM FORM FOR CANCER BENEFITS

<b>1. CLAIMANT'S DETAILS</b>		
Name		
ID Number		
Policy Number		
<b>2. PAYEE DETAILS</b>		
For your protection, payment will only be effected by Electronic Fund Transfer. Payment will only be made to the claimant.		
Name		
Bank name		
Account number		
Account type		
Bank code		
<b>3. PERSONAL DETAILS</b>		
Tel No: (Home)	Tel No: (Business)	Cellphone No:
<b>4. DIAGNOSIS</b>		
a) Nature of the Illness		

**CLAIM FORM FOR CANCER BENEFITS (continued)**

b) If the impairment was due to illness/disease, please provide the following details:				
i. Date the illness/disease was first diagnosed				
ii. Name and address of all attending doctors				
iii. What prescribed treatment are you currently taking?				
iv. Name and address of your usual attending doctor during the past 5 years				
v. History of all medical consultations/treatment over the past 5 years (treatment for flu and colds may be omitted)				
Dates	Reasons	Treatment	Hospital/Doctor	Tel. no

## 5. DECLARATION

I hereby warrant and declare that the foregoing answers and statements are true and correct to the best of my knowledge and belief, and that I have withheld no material fact from MS Life. I further declare that the condition giving rise to this claim was not due in any way to self inflicted injury or use of alcohol or drugs of any kind.

I agree that the written statements and affidavits of all the doctors who attended or treated me and all other papers submitted in support of this claim, shall constitute and are hereby made a part of this claim, and further agree that the supply of this form, or any other forms supplemental hereto by MS Life, shall not constitute and admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defences in law.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge or consent, have knowingly withheld any material fact or submitted any false information in respect of this claim. I further agree that upon payment of the benefits hereby claimed, MS Life shall be discharged from all liability in respect of such benefit.

I hereby authorise any medical practitioner, hospital or any other person to furnish to MS Life, or its representative, any details relating to any illness or injury to the Life Assured or such other information as may be necessary to consider this claim. I know and understand the confidential nature of medical information. By appending my signatures at the end of this Personal Declaration, I am agreeing that I have given permission to MS Life to obtain medical information and evidence from and/or through third parties without it being seen as a breach of my right of privacy and confidentiality. I further agree that any authorised medical personnel or practitioner may release confidential information to MS Life or other persons acting on their behalf and in such manner or method as may direct.

I indemnify MS Life and its directors, agents and employees against any claim of whatever nature which may be made against them as a result of or arising out of the furnishing of such information. Where the conditions of the contract so allow, I irrevocably authorise MS Life to deduct any expenses incurred by it in respect of this claim and for which I am liable from the benefits payable under the contract.

Claimant's signature	
Date	

### **Please submit the following documents required:**

- A certified copy of your ID document
- Proof of your account (payslip/bank statement/cancelled cheque)
- Clinical records & histology reports